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ABSTRACT

The manual describes the Family, Infant, and Toddler Project for rural handicapped preschoolers and their families. The project, based on an ecological perspective, has three goals: to develop a demonstration service program, to increase the pool of qualified personnel, and to expand educational services to preschool aged mentally retarded children and their families in rural areas. Techniques used in establishing the program in rural communities are described. Referral, screening, and evaluation procedures (which include psychological and educational evaluation as well as family interviews) are described. The operation and design of the rural educational clinic are summarized in terms of facilities, staffing patterns, scheduling, liaison, program planning for families, and recordkeeping. Extensive appendixes include sample letters and forms, sample screening and evaluation reports, and parent interview summaries. (CL)

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FAMILY, INFANT, AND TODDLER (FIT) GUIDE

A Model for Rural Family-Implemented Educational Programs

Editor
Ann B. Carr

Family, Infant, and Toddler Project
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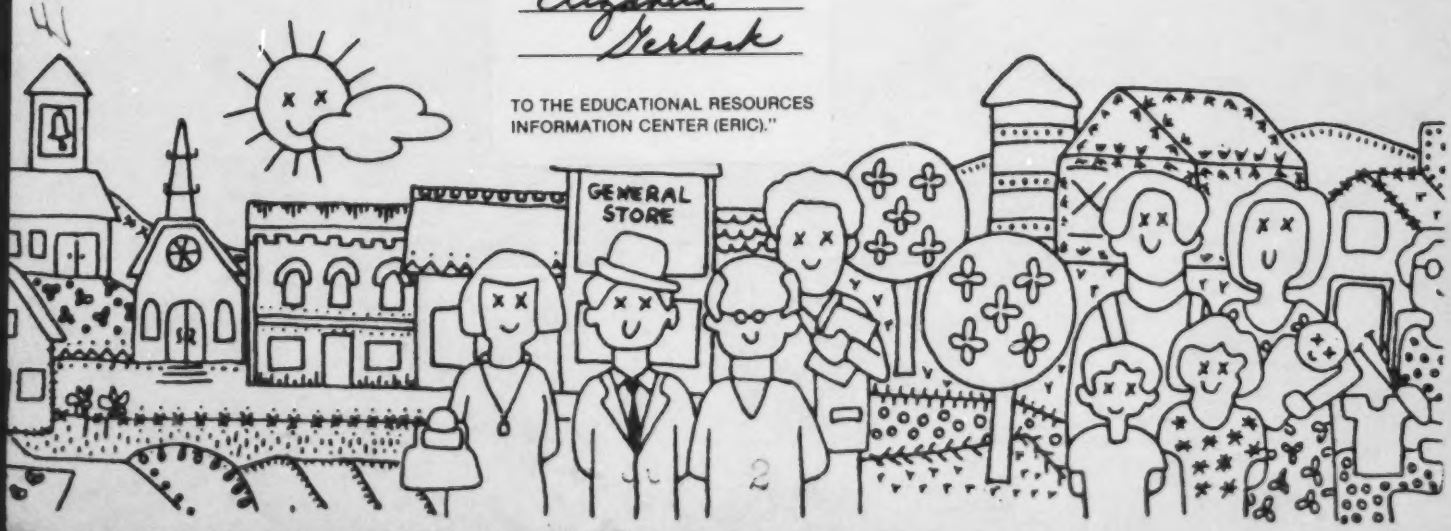

The Family, Infant, and Toddler Project demonstrated a model for providing educational services in rural settings for families of young children with retardation and other handicapping conditions. Based in Middle Tennessee, FIT Project staff members worked with children age birth through four, their families, and the local professionals who assisted them.

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Family, Infant, and Toddler (FIT) Guide
A Model for Rural Family-Implemented Educational Programs

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June, 1982

Dedicated To. . .

Annie Sevier (March 3, 1979-April 2, 1981)

and her family.

PREFACE

The Family, Infant, and Toddler (FIT) Project began in July 1978. The major goal of the Project was to develop an effective model for bringing educational and supportive services to preschool-aged handicapped children in rural communities. Beginning with a conceptual framework, a general plan of approach, and boundless energy and optimism, the Project staff began building a working educational model. By the summer of 1981, 3 years later, the FIT Project staff had transformed their concepts and plans into an effective, model-demonstration program with four self-sustaining educational programs in rural Middle Tennessee.

This paper is designed as an operational manual for educational administrators, teachers, and other professionals interested in replicating the FIT Project model for preschool-aged handicapped children and their families in rural communities. The manual provides a detailed description of the FIT Project model so that the entire model or individual components can be adopted by other early intervention programs.

The FIT Project emerged from the dedicated efforts of the entire staff. Staff members gave freely of their energy, creativity, sensitivity, and especially, their genuine caring for the children and the families they served. Their remarkable work brought the FIT Project to life and to maturity during the past 3 years. The staff members of the FIT Project are listed below:

Harris Gabel	Project Director
Judith A. Davis	Training Coordinator and Project Coordinator
Mary Porter	Training Coordinator
Ann Ballentine Carr	Infant/Family Teacher
Elizabeth Gerlock	Infant/Family Teacher
Maria N. Donofrio	Infant/Family Teacher and Program Evaluator
Jacqueline Bly Sweat	Infant/Family Teacher
Vivian Correa	Infant/Family Teacher
Gayle Prillaman	Infant/Family Teacher
Christine Giordiano	Infant/Family Teacher
Valerie Sweeney	Infant/Family Teacher
Myrtle Diane Smith	Infant/Family Teacher

Vaughan Stagg	Program Evaluator
Carolyn Liu	Secretary
Katherine Glass	Secretary
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Louise Phillips	Consultant

Harris Gabel
October 6, 1981

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INTRODUCTION

Project Background

Many obstacles exist to providing effective social, medical, and educational services for retarded persons in rural communities, for example, scarcity of specialized professional personnel, geographic isolation, and dispersion of target populations. Therefore, rural communities must find specialized ways of delivering these services. These difficulties in providing services for preschool-aged retarded children in rural areas nationally are reflected locally in Middle Tennessee and became apparent to agencies serving this population.

Since 1972, the Early Developmental Assistance Program at the Experimental School of The John F. Kennedy Center for Research on Education and Human Development, George Peabody College for Teachers, has provided educational programs for mentally retarded children of preschool age using the model described by Bricker and Bricker (1975). In 1977, the Center-based Early Developmental Assistance Program emphasized parent training and the integration of handicapped and nonhandicapped children. The program included weekly educational clinics for infants, half-day programs for preschool children, and a full-day preschool program. The Early Developmental Assistance Program became a major regional resource for early intervention information, and the Experimental School began receiving requests for assistance from professionals and families in the rural communities surrounding metropolitan Nashville. The staff responded by developing a modest outreach program. Periodic home visits were made to five families with preschool-aged mentally retarded children in a rural community 75 miles southeast of Nashville. Additional outreach efforts included consultation with other early-intervention programs with the goal of enhancing their capacity to provide educational services for preschool-aged retarded children.

It became clear to the staff that these modest efforts were insufficient and that a different kind of program was required to meet the needs of preschool-aged retarded children in rural Middle Tennessee. Viewing the problems and resources in Middle Tennessee as representative of similar regions throughout the country, the FIT Project was created in 1978 to provide a model for meeting the educational needs of preschool-aged mentally retarded children in rural communities nationwide. The FIT Project was a "First Chance" Project supported by the Office of Special Education, U.S. Department of Education with matching funds supplied by the Tennessee Department of Mental Health and Mental Retardation.

Overview of FIT Guide

During the development and operation of the FIT Project, the staff was guided by an ecological perspective of the preschool-aged mentally retarded children they hoped to serve, i.e., that the children did not function alone but in a social system of parents, siblings, relatives, friends, and neighbors. The following section describes this guiding framework and the

Project's goals. Since the success of an early-intervention program in rural areas is heavily influenced by the initial approach to program development, the next section also describes how the FIT Project was started in rural communities. The details of the model itself begin with a description of the referral process and with the procedures for screening children for eligibility for FIT Project services. If found to be appropriate for the Project, children were given a comprehensive psychoeducational evaluation. Children and parents then participated in rural education clinics in their own communities. The clinics are at the core of the FIT Project model, so they are described in detail. A discussion of the evening clinics for extended-family members of the preschool-aged mentally retarded children is also included.

CONCEPTUAL ORIENTATION AND PROJECT GOALS

Conceptual Orientation

The FIT Project staff was guided by an ecological perspective. In this framework, children are viewed as functioning and developing as parts of a social system (Hobbs, 1966). Thus, preschool-aged mentally retarded children are seen as part of both nuclear families, and as part of broader extended families. Nuclear families include parents and their children; and extended families include the extended-kinship system, persons related to the nuclear family by blood or marriage, and the informal-kinship system consisting of friends, neighbors, and associates (Pattison, Defranciso, Wood, Frazier, and Crowder, 1975). Both mentally retarded children and their families operate within larger systems in their communities. For these children and families who are frequently in need of specialized human services, the social, educational, and medical service-delivery systems are particularly important. The political elements of the broader community are also relevant since they influence the quality and availability of required professional services.

Professionals guided by the ecological perspective philosophy believe that children and their social systems are interdependent (Holahan, 1977). Changes in one part of a system are assumed to reverberate and have an impact on other elements. Thus, children can benefit from intervention aimed at their families and their communities. In this sense, the targets for intervention include the family and the community systems with the children as the central focus within them.

Families and communities, especially the community of local professionals, are important potential resources for preschool-aged mentally retarded children in rural areas. Consistent with the ecological viewpoint articulated by Holahan (1977), the aim of the FIT Project staff was to enhance the competence and potency of families and of professionals as they worked to facilitate the development of preschool-aged mentally retarded children.

Another major theme related to an ecological orientation is the strengthening of linkages between the systems affecting preschool-aged mentally retarded children (Thompson, 1979). Linkages are mechanisms for coordination and transfer of such elements as resources and social support among systems. Because stronger linkages should result in increases in helpful exchanges among systems, one aim of the Project staff was to build stronger linkages between parents and children, between parents, among professionals and parents, and among local

professionals and agencies. Perhaps the most vital linkage that needs strengthening is that between extended families and nuclear families, since this linkage may weaken when mentally retarded children are born.

Caplan's (1976) analysis of the family as a support system provides a basis for understanding ways in which the birth of mentally retarded children may deprive parents of needed support from their extended families. According to Caplan, a major function of families is the collection and transmission of information about the world. Family members are usually the beneficiaries of information stored and transmitted by other members of their families. Grandparents, for example, may be important reservoirs of information relevant to rearing normally developing children, but they are less likely to be knowledgeable about useful rearing strategies for mentally retarded children.

Extended families also are less likely to provide constructive ideologies, another important support function of families, when mental retardation is identified. Family ideologies regarding mental retardation consist of beliefs, values, and codes of behavior. For some rural families, ideologies of extended families may be unsupportive of nuclear families attempting to rear mentally retarded children at home and to provide intensive educational experiences.

Another supportive function of extended families is the provision of guidance and practical assistance in dealing with everyday problems. Once again, since the extended-family members are less likely to have experience with mentally retarded children than with normally developing children, their ability to support parents by providing guidance and practical assistance may be attenuated.

Finally, extended families are important sources of support for gaining emotional stability when nuclear-family members face crises. Births of mentally retarded children commonly precipitate family crises (Moroney 1976). Paradoxically, just when parents are experiencing these difficult crises, grandparents may be so upset themselves by the birth of handicapped children that they are unable to provide the much needed emotional support to parents.

Therefore, while extended families are potential sources of support in rearing mentally retarded children, their effectiveness may be diminished. The strengthened linkage between extended families and nuclear families should lead to increased social support.

Project Goals

The ecological perspective adopted by the FIT Project staff was an integrated effort aimed at children, families, and communities. Goals and objectives were formulated for these intervention targets. The activities designed to achieve these objectives are interrelated so that the overall Project was a closely coordinated effort in each community.

The first goal of the Project staff was to develop a demonstration service program for preschool-aged mentally retarded children and their families in predominantly rural areas of Middle Tennessee. The objective for the children was to provide family-mediated educational programs to enable the children to reach their full developmental potential. The Project staff trained and assisted nuclear families, primarily parents, in implementing educational programs for their preschool-aged mentally retarded children. For extended families, the Project staff's objective was to assist them in supporting nuclear families.

The FIT Project staff's second goal was to increase the pool of personnel qualified to serve the target population. Professionals who dealt with the education of preschool-aged mentally retarded children needed to be trained and an in-service training program that could be replicated needed to be developed. The major objectives associated with this goal consisted of developing and implementing a prototype training program. evaluating and revising the prototype, field testing it, and preparing the final product for dissemination.

The third goal was to expand educational services to preschool-aged mentally retarded children and their families in predominantly rural areas. The objectives for this goal were to increase public awareness and understanding both of the children and of the potential value of early intervention, to stimulate interest and support for additional programs for this population, and to provide technical assistance to local agencies interested in and capable of expanding educational services to preschool-aged mentally retarded children.

ESTABLISHING THE PROGRAM IN RURAL COMMUNITIES

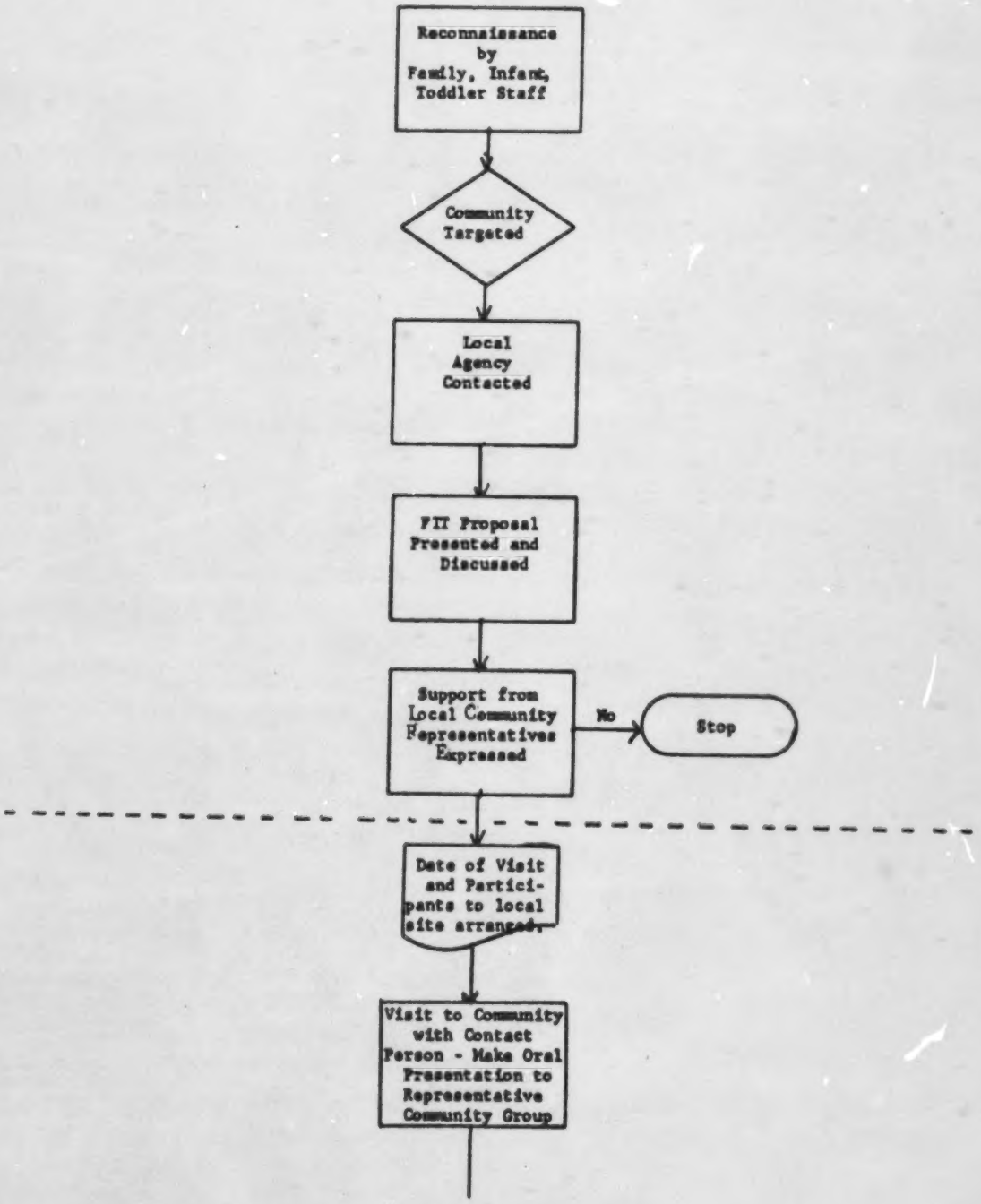
Since federal support for the Project was limited to 3 years, responsibility for continuation of the program would be primarily in the hands of state and local agencies. The probability of continuation beyond the period of federal support was directly related to how well the program related to state agencies, especially to local communities during its operation. The way the program was introduced in rural communities was particularly important to generating future support. This section presents a brief discussion of the approach used to start the Project. (See Figure 1 for a flow chart representing the community entry process.)

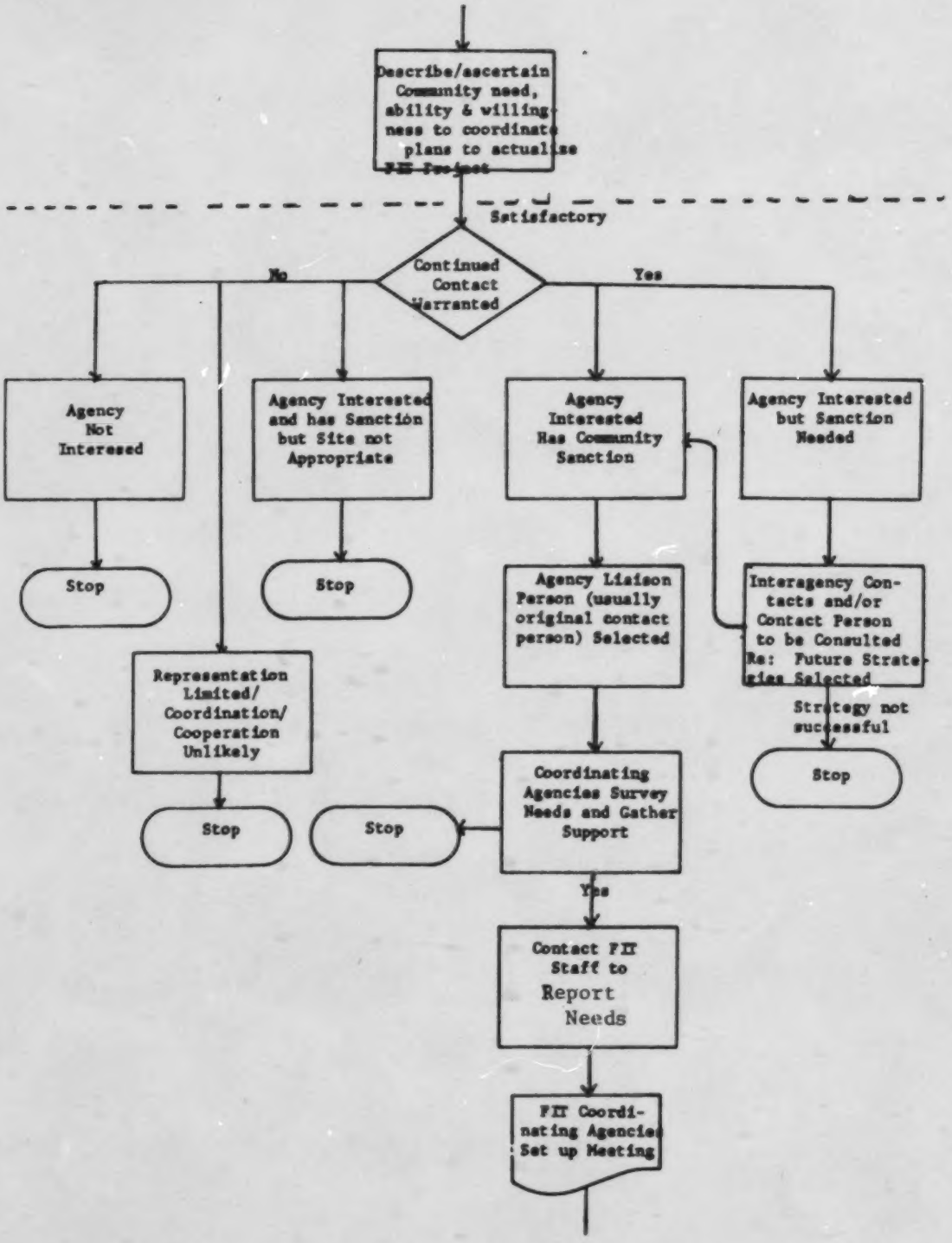
The FIT Project staff established programs in four counties using four resources as criteria for selection. First, communities with at least five eligible children were sought. Second, the communities selected for the Project had to have both agencies and professionals interested in participating in the training program for allied professionals. These agencies and professionals were expected to sustain services over a long period of time. Third, it was necessary to identify physical locations for Project activities; and finally, local agencies willing to assist Project clients with transportation had to be found.

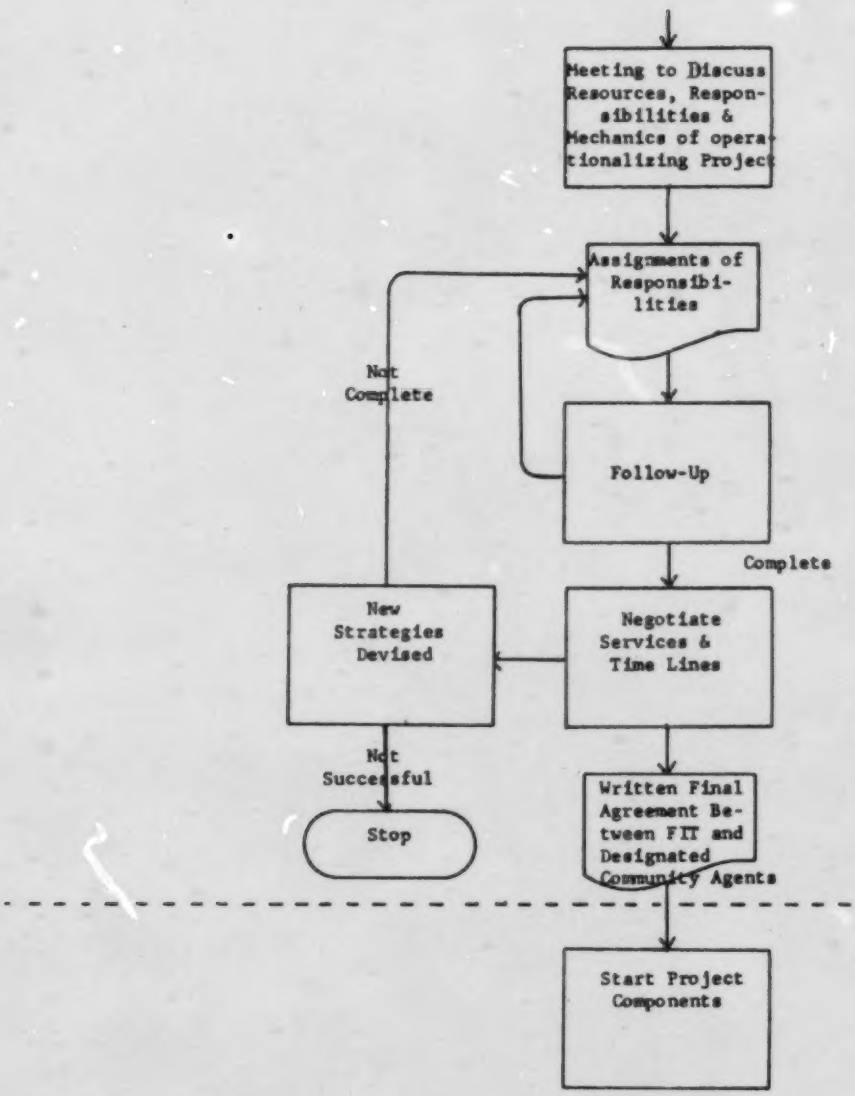
In the beginning, Project staff members usually contacted local human service professionals first. It was essential for local professionals and agencies to share with the FIT Project staff a sense of responsibility for alleviating some of the problems of preschool-aged mentally retarded children and their families. Furthermore, the staff aimed to develop a sense of shared ownership of the Project and its solutions to some of these problems. Thus, in the consultation process with organizations (Schein, 1969), the FIT Project staff worked to identify and foster a feeling of community ownership of the problems and solutions from the very beginning. These principles have been applied successfully in initiating programs in other communities (e.g., Strauss and Stowe, 1974).

In the FIT Project communities, local professionals already were keenly aware of the need to develop additional services for the target population. In general, they had been serving these preschool-aged mentally retarded children and their families as well as they could; but local professionals also clearly recognized their own limitations. After hearing a description of the FIT Project, most professionals accepted it as a potentially useful program.

Figure 1 - The FIT Community Entry Process


Reconnaissance by Family, Infant, Toddler Staff
Community Targeted
Local Agency Contacted
FIT Proposal Presented and Discussed
Support from Local Community Representatives Expressed
No
Stop
Date of Visit and Participants to local site arranged.
Visit to Community with Contact Person - Make Oral Presentation to Representative Community Group


Describe/ascertain Community need, ability & willingness to coordinate plans to actualize FIT Project
Satisfactory
Continued Contact Warranted
No
Yes
Agency Not Interested
Agency Interested and has Sanction but Site not Appropriate
Agency Interested Has Community Sanction
Agency Interested but Sanction Needed
Stop
Stop
Agency Liaison Person (usually original contact person) Selected
Interagency Contacts and/or Contact Person to be Consulted Re: Future Strategies Selected
Strategy not successful
Stop
Representation Limited/ Coordination/ Cooperation Unlikely
Stop
Stop
Coordinating Agencies Survey Needs and Gather Support
Yes
Contact FIT Staff to Report Needs
FIT Coordinating Agencies Set up Meeting

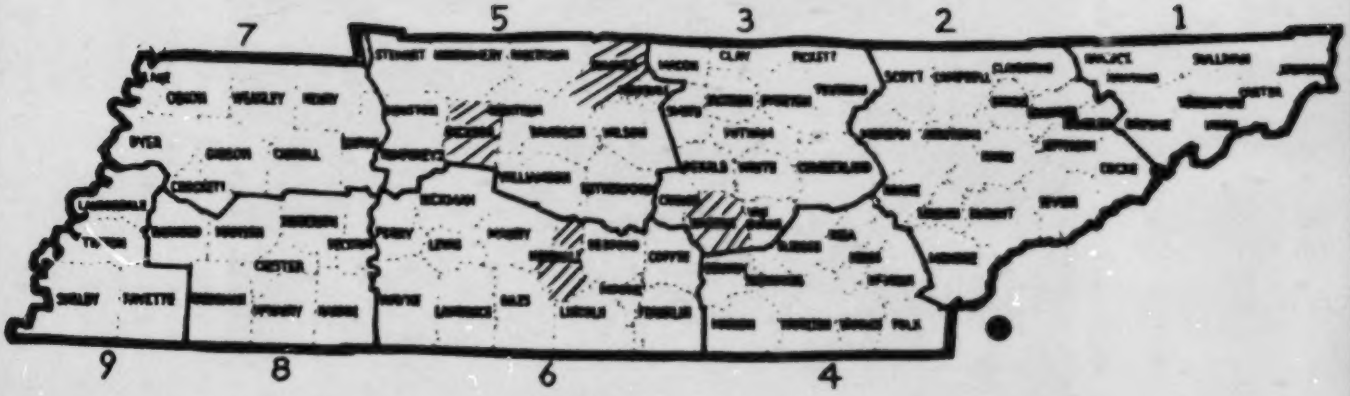

Meeting to Discuss Resources, Responsibilities & Mechanics of operationalizing Project
Assignments of Responsibilities
Not Complete
Follow-Up
Complete
New Strategies Devised
Negotiate Services & Time Lines
Not Successful
Stop
Written Final Agreement Between FIT and Designated Community Agents
Start Project Components

Consistent with the theme of local participation, the staff asked for help from local professionals to find space for Project activities and for transportation for the handicapped children. Local professionals made the necessary arrangements easily in each instance. For example, local professionals arranged with church authorities to house the intervention programs in their facilities; and they arranged with existing transportation resources in their communities to provide transportation for the handicapped children to the program sites. Rural health program staff in one community agreed to assist with these arrangements in their area.

The active participation of local professionals in the FIT Project was greatly facilitated by Project training meetings. Training meetings gave local participants an opportunity to make additional plans for continuing the Project (Gabel, 1981). The Project staff participated actively and lent support whenever possible. These discussions ultimately were successful since all of the programs continued beyond the period of federal support.

An education intervention program for preschool-aged mentally retarded children and their families and a training program for local allied professionals was developed in four counties. (See Figure 2.) In November 1978, the FIT Project began operations in Lewisburg, the county seat of Marshall County, Tennessee. Located approximately 60 miles south of Nashville, Lewisburg has an estimated population of 18,000 in an area of 377 square miles. The second FIT Project program began operations in April 1979, in Dickson, Tennessee. Dickson is the major town in Dickson County and is located approximately 45 miles west of Nashville. The county population is about 26,000 in an area of 485 square miles. McMinnville, Tennessee, the county seat of Warren County, was the third site. The Project began activities there in June 1979. With a population close to 29,000, Warren County covers 439 square miles and is located approximately 75 miles southeast of Nashville. The fourth site was initiated in July 1980 in Gallatin in Sumner County. This site is located approximately 40 miles north of Nashville. The 85,000 people in Sumner County reside in an area of 535 square miles.

TENNESSEE DEVELOPMENT DISTRICTS



Region One - First Tennessee Development District

Region Two - East Tennessee Development District

Region Three - Upper Cumberland Development District

Region Four - Southeast Tennessee Development District

Region Five - Mid-Cumberland Development District

Region Six - South Central Tennessee Development District

Region Seven - Northwest Tennessee Development District

Region Eight - Southwest Tennessee Development District

Region Nine - Memphis-Delta Development District

Figure 2 - Tennessee Counties with FIT Clinics

3

CHILD REFERRAL, SCREENING, AND EVALUATION

Referral Procedures

As part of the initial negotiations for establishing FIT Project clinics and as part of Project-community collaborations, local professionals needed to identify a minimum of five preschool-aged handicapped children potentially eligible for Project services. Identifying five preschool-aged handicapped children was one of the four criteria for establishing clinics in the communities. The Project staff informed all potential referral sources about openings for preschool-aged handicapped children in the FIT Project clinics. Children ranging in age from birth to 4 years with suspected developmental problems were appropriate referrals.

Referrals could come from anyone in the community including families, local and regional agency staff, and church personnel. Referral sources had to obtain parent permission for the referrals prior to contacting the Project staff. The Project staff requested verbal referrals initially to be followed by letters from the referral persons or agencies. The letters provided the children's names and ages, the parents' names and addresses, and general information about the children's suspected developmental problems. (See Appendix A for a sample referral letter.)

Upon receipt of the referral letters, Project staff members began arranging for home visits to screen the children and their families.

Screening Procedures

Initial Contacts

Letter. Following the referrals, the Project staff sent letters to the families for the typical first contact. Parents were contacted by letters first to allow them time to think about the implications of participating in the Project prior to direct contact with staff members. In these letters, the parents were provided with information concerning who referred them, a description of Project services, and the time and location of the weekly educational clinics in their geographic area. The letters also described the home visits and the comprehensive evaluation. Home visits were for the purpose of screening referrals to determine the need for further evaluation and for eligibility for Project services. The comprehensive evaluations were for enrollment in the Project. Additionally, a brief explanation was included in the letters

regarding the purpose and the kinds of information gathered through screening and evaluation procedures. (See Appendix B for a sample initial contact letter.)

Finally, the letters requested parents to call the staff member who wrote the letter if they were interested in participating in the Project or wanted more information. If families did not respond to these requests within 10 days, the Project staff member called, or wrote another letter, if the families did not have phones.

Copies of all correspondence were sent to the referral sources.

Telephone contact. After the first letter, typically the Project staff member and a family member talked by telephone. Often, families wanted more information concerning the Project before consenting to home visits and screening. Families usually asked for information about the ages and types of children served in the clinics, about fees (there were no fees), about relatives or regular babysitters participating in the weekly clinics if both parents worked, and about how long the program would be in operation.

The Project staff also was interested in gathering more information about the retarded children and their families in these telephone conversations prior to scheduling home visits. Of particular interest to the Project staff was information concerning the extent of the children's developmental delays, the handicapping conditions, the availability of family members to participate in the weekly clinics, and other agencies involved with the children and their families.

Families were provided additional information about Project services, including the Project staff's commitment to training local professionals in educational intervention methods for preschool-aged handicapped children. Parents were given brief explanations about how local professionals trained in the weekly clinics with the children as a supervised practicum. If permission was granted by the parents, local professionals also participated in home visits for training in the use of the Denver Developmental Screening Test. If permission for the presence of specified local professionals (often the referral sources) to be present during the home visits was denied during the telephone contacts, parents were assured there would be no negative consequences for refusal of this request.

Occasionally, these conversations yielded information indicating needs of families or children that could be served more effectively through other programs. In such situations, the Project staff offered to assist families in locating services better suited to their needs.

Home Visit

The Denver Developmental Screening Test was used by the Project staff as its screening instrument. Prior to conducting the screening tests with the children, the staff members explained to the parent(s) the application and permission forms to be completed during the home

visits. These forms included permission for the Project staff to conduct the evaluations of the children, applications for the children's evaluations, consent forms for photographs, and consent forms for local professionals participating in the training program to work with the children. (Samples of these forms are in Appendix C.) Also, permission was obtained from the parents for the Project staff to request information from other agencies involved with the children. Typically, the process of completing the applications for the children's evaluations provided general descriptions of the children's developmental histories and agencies involved.

After completing the various application and permission forms, the screening tests were conducted with the children. Items were explained to parents as they were administered to the children. Thus, the parents knew what developmental skills and conceptual understandings the children were demonstrating during the screening procedures. The tests were scored during the home visits and general feedback was provided to the parents. Most often, the various communications between Project staff and parents prior to the actual screenings provided sufficient information regarding the children's eligibility for Project services. Thus, following general feedback to the parents of the actual screening results, dates convenient for the parents were arranged for comprehensive evaluations of the children.

The local professional trainees participating in the home visits often were people involved in some service capacity with the families. Thus, they often functioned both as trainees and as liaisons. As trainees, the local professionals observed the process of conducting the home visits, and observed and practiced the administration of the Denver Developmental Screening Test. As liaisons, they were able to answer any questions concerning local or regional services. Also, the local professionals functioned as advocates for families and children to the Project staff and provided links between past, present, and anticipated child/family needs as they related to Project services.

Screening Report

Parents were told they would receive copies of the written screening reports within 3-to-4 weeks of the home visits. Permission was requested by the Project staff to send copies of the reports to the referral sources as well.

The screening reports were comprised of four sections. The first section was a brief summary of background information. More extensive information was collected during the comprehensive evaluation. Other sections included the screening summary and behavioral observations, family situations, and recommendations. (A sample screening report is in Appendix D.)

Evaluation Procedures

Purpose

After screening, the next contact by families with the FIT Project staff was for the comprehensive evaluations. The evaluations usually took one-half day to complete. They consisted of three major sections: (a) psychological evaluations; (b) educational evaluations; and (c) family interviews. The evaluation data were used to determine eligibility for FIT Project services. The evaluations resulted in estimates of the children's current levels of psychoeducational functioning. This information was often of great interest to parents who wished to understand the nature and extent of their children's handicaps. Information about current functioning levels was important also for purposes of program evaluation. The final and most important use of the evaluation information was to determine a set of appropriate educational objectives and plans for achieving these objectives with the preschool-aged handicapped children. Thus, the information gathered during the evaluations was essential for developing the Individual Educational Plan.

Psychological Evaluation

The central contribution of the psychological portion of the evaluations was in determining the overall levels of development of the preschool-aged handicapped children using standardized, norm-referenced evaluation procedures. The evaluations also included assessments of the children's temperament during the evaluations and observations of the social interactions between the preschool-aged handicapped children and their parents.

The Bayley Scales of Infant Development (Bayley, 1969) were used in the psychological evaluations. The Mental Scale provided data concerning overall developmental levels, while the Infant Behavior Record was completed to systematically record data relevant to understanding the temperament of the preschool-aged handicapped children. Assessments of the social interactions between parents and their children were based on informal observations of these interactions during the assessment day.

The Bayley Mental Scale was administered following standardized procedures described in the manual (Bayley, 1969). However, since many of the preschool-aged handicapped children evaluated presented either physical impairments such as cerebral palsy or sensory deficits, the administration of the complete Scale in a standardized fashion was not possible. Therefore, in conducting the evaluations, the evaluators omitted items that could not be presented reasonably to particular children. For example, items requiring visual tracking were not scored for children with known visual impairments. The remaining items, however, were administered in a standardized fashion using standard materials and scoring criteria.

The omission of more than three items on the Bayley Mental Scales could invalidate the Bayley scores (Bayley, 1969). Therefore, for those preschool-aged handicapped children with more than three missing items the test scores were interpreted as clinical estimates of developmental levels rather than as psychometrically valid test scores.

Educational Evaluation

Educational evaluations were a component of the psychoeducational evaluations. The primary purposes for the evaluations were to provide baseline data about the children's developmental levels upon entry into the program and to provide information for educational programming by teachers for the preschool-aged handicapped children.

The Uzgiris-Hunt Scales of Infant Psychological Development (Uzgiris-Hunt, 1975) and the Griffiths Mental Development Scale (Griffiths, 1970, 1976) were the primary instruments used for the educational evaluations. Other instruments also were used with some of the children to provide additional information. Examples are: The Functional Vision Inventory (Langley, H.B., 1979), Maxfield-Bucholz Scale of Social Maturity for the Use with Preschool Blind Children (Maxfield, K. and Bucholz, S., 1957), Oregon Skills Inventory for Visually Impaired and Blind Preschool Children (Brown, D., Simmons, V., and Methvin, J., 1979), Peabody Developmental Motor Scales, Folio, R., & DuBose, R., 1982, and Sequenced Inventory of Communication Development (Hendrick, D., Prather, E., and Tobin, A., 1979). The Uzgiris-Hunt Scales provided information about the children's development within a Piagetian sensorimotor framework. These scales, which are not norm-referenced on the functioning levels of the preschool-aged handicapped children within the following domains of sensorimotor development: (a) object permanence; (b) means-ends; (c) spatial relations; (d) gestural and vocal imitations; (e) operationsl causality; and (f) schemes for relating to objects. The Griffiths Scale, a norm-referenced instrument, is broken down into the following areas of development: (a) personal-social; (b) hearing and speech; (c) locomotor; (d) eye-hand; and (e) performance. Glocal developmental ageas as well as individual subscale ages can be obtained with this instrument.

The primary difference between the administration of the psychological and educational assessment procedures was the much greater degree of leeway the educational evaluators had in administering the tests than did psychological evaluators. In order to determine the children's optimal levels of functioning and learning styles, educational evaluators could depart from the standardized format if needed. Adaptations were especially important in assessing multiply-handicapped children because their physical and sensory deficits often prevented them from responding to specific test items. The educational evaluators attempted to determine what effects the children's physical and sensory handicaps had on their ability to respond to stimuli. Modifications were then made whenever possible to adjust for these handicaps. Modifications included: (a) adapting the children's seating or positioning them in a way that would minimize the effects of abnormal or immature motor development; (b) presenting materials to correspond with the children's intact abilities; (c) adjusting the response modes required of the task to correspond with the children's abilities; and (d) sustituting materials to correspond with the children's physical abilities

and interests, while still eliciting the basic concepts underlying the best items (Fieber, 1977; Robinson & Robinson, 1978).

The following example illustrates how the educational evaluators adapted a test to multiply-handicapped children. The Uzgiris-Hunt Scale was administered to a 3-year-old male child with cerebral palsy, hearing deficits, and a very poor attention span. In order to administer the object permanence tasks on the Uzgiris-Hunt Scales, the evaluator first positioned the child in a way that provided as normal posture, muscle tone, and movement patterns as possible. The child was placed in a cube chair, with his knees flexed, feet flat on the floor, towels wedged into the side of the chair to provide trunk support, and his mother bracing him across the upper chest to improve trunk and shoulder stability so that he could use his hands and arms as efficiently as possible. Because his head control was not fully developed, materials were presented directly in front of his eyes so that he would only have to turn his head slightly to scan them. Since he responded best to two or three favorite toys, these toys were used as the objects to be hidden. Because his fine motor skills were limited, looking or moving his hand toward the proper item was an appropriate response. By gearing the presentation of the test items to the child's abilities, it was possible to determine whether failure on the items was due to his inability to process the underlying concepts or to difficulties in physically performing the task.

While a rough developmental age levels were obtained for the children with the educational assessments, the primary purpose of the evaluations were to provide information that would assist teachers in educational planning. The educational evaluators generally developed a number of short-term educational objectives with specific activities designed to meet those objectives as part of the written educational reports. These activities and objectives were then incorporated into the children's Individualized Educational Plan.

Family Interview

Family interviews also were conducted as part of the complete psychoeducational evaluations. The general purpose of the interviews was to understand the family context in which preschool-aged handicapped children developed. With this information, the staff would be able to formulate a set of intervention procedures for individual families. Both parents were included in the family interviews when possible. Parents could include grandparents and other family members in the family interview if they accompanied the parents for the evaluation appointment.

Family interviews covered several topics. They began with careful reviews of the children's developmental histories. Parents were asked to describe their pregnancies, the children's births, and the children's early development. Interviewers were interested not only in developmental milestones and significant medical data but also in parents' own reactions and feelings about these events. Parents were then asked to provide their views of their children's current levels and patterns of development. Some parents were able to provide the interviewers with

their own estimates of the current developmental status of their children. The next topic in the family interviews was the current family environment. Parents were asked to describe their home environments and typical days in the lives of the children and their families. Interviewers were also interested in parents' views and expectations for the future of their children and their families. Finally, to gain information about parental hopes and goals for their children, the interviewers discussed the parents' current concerns about their children and their families.

These topics were discussed in a flexible manner by the evaluators to allow parents to express their views fully on the topics most important to them. Throughout the interviews, parental feelings, views, hopes, and concerns were emphasized while factual data concerning the children and their families was gathered.

Interpretive Interview

The psychological evaluations, the educational evaluations, and the family interviews usually were completed in one morning. During the lunch break, the staff members participating in the evaluations met for conferences. The evaluators shared information about the children and their families, formulated diagnostic impressions of the children, and developed initial recommendations for the educational clinic staff and the families.

After the lunch hour, the findings of the evaluators were interpreted for the parents. Members of the evaluation team conducted the interpretive interviews. If parents wished, other family members who accompanied them to the appointments also were invited to the interpretive conferences.

Since parents often required additional interpretations of evaluation data as part of the clinic program, the staff members who would later work with the parents in the educational clinic program often were invited to observe the interpretive interviews, with parental permission. Parents received complete copies of the reports of the psychoeducational evaluations when they were completed, and these written materials were reviewed during the educational clinic sessions. (A sample set of evaluation reports are included in Appendix E.)

4

RURAL EDUCATIONAL CLINICS

Theoretical Orientation

The FIT Project clinics operated in four rural communities providing services to preschool-aged handicapped children and their families. The purpose of the educational clinics was to provide a model structure and atmosphere that helped family members facilitate the development of their preschool-aged handicapped children. The clinics provided parents and family members with specific information about their handicapped children, with training in implementing educational programs and with emotional support in dealing with their handicapped children.

The FIT Project staff's focus on family-mediated intervention was manifested in the various operations of the educational clinics. Family members (usually the parents) and the family/infant teachers formed teams to implement the educational programs for the children. The parents were considered competent members of the team. They provided information regarding such things as the children's behavior, their likes or dislikes and their preferences for carrying out activities with certain family members. The teachers provided knowledge of assessment, educational programming, and utilization of other existing resources. The role of the parents was to implement activities with the children in the clinics and in their homes. The teachers functioned as consultants, coordinators, and trainers of specific skills to the parents. Because the families were a focus of the intervention, one family member was required to attend the clinics with their handicapped children. This family member typically was the mother, but fathers, aunts, siblings, grandparents, and friends also attended the clinics. The FIT Project clinics periodically offered the clinics at night specifically to involve the extended-family members in the clinic activities.

Parents were not prescribed activities for their children that were pre-set. The FIT Project staff encouraged families to adapt and modify activities to fit into the families' routines. During the individual training sessions, the family members and the teachers started with an explanation of the concepts of the activities and then discussed the best activities to teach the concepts to the children. Simple object permanence tasks in which the parents covered objects in the child's view could take place in several contexts during the day. Family members could hide the baby powder at changing time, or cover the soap with a washcloth at bathtime, or cover a cracker with a bib at feeding time.

The parents and teachers made every effort to design tasks so that the same concept could be worked on with many different objects and in many different situations. In this way, the FIT Project hoped to foster the teaching of concepts that could lead to generalization of the task rather than emphasizing the mastery of specific, isolated skills. Conceptual teaching was the foundation of the intervention packages designed for each child.

The family situation was assessed during the family interviews at the initial psychoeducational evaluations prior to setting goals for the educational programs. Priorities and special concerns of the families for their children also were assessed before the initial activities were assigned.

The FIT Project clinic staff provided emotional support to families as well as strengthened the linkages with other families. The weekly clinics provided parents and family members a time to meet people that were faced with similar situations. For some families, the clinics offered one of the few places where their children were accepted unconditionally. The clinic schedule was arranged so that a specific time each week would foster adult-peer relationships. The last hour of the clinics was set aside specifically ror adults to share their experiences, to raise questions, and to deal with some of the realities of having handicapped children. Some of the families extended the relationships built during the clinic hours to the rest of the week. The parents who were trained together initially soon started training each other, especially when new families joined the clinic groups. The supportive atmosphere that soon developed among the clinic participants enhanced the entire clinic operations.

Similar times were set aside for the extended-family members at the evening clinics. They also had a chance to share their experiences, to raise questions, to address issues regarding support to the nuclear families and to deal with their own feelings.

Operational Structure

Clinics were held one morning a week in the four communities for 3-hour sessions. Usually, five children, their family members and two family/infant teachers attended the clinics. Approximately every 6 weeks the clinic times were shortened to 1-3/4 hours to allow participation of extended-family members at night clinics. These clinics were referred to as Evening Family-Meeting clinics. Approximately every 3 months the FIT Project clinics were replaced by home visiting days so that the teachers could visit the parents and their children in their homes. The following sections provide a more detailed description of each phase of the FIT Project clinic operations.

Physical Facilities

Rooms. Local professionals in the four communities that established FIT clinics, located churches willing to donate space for FIT

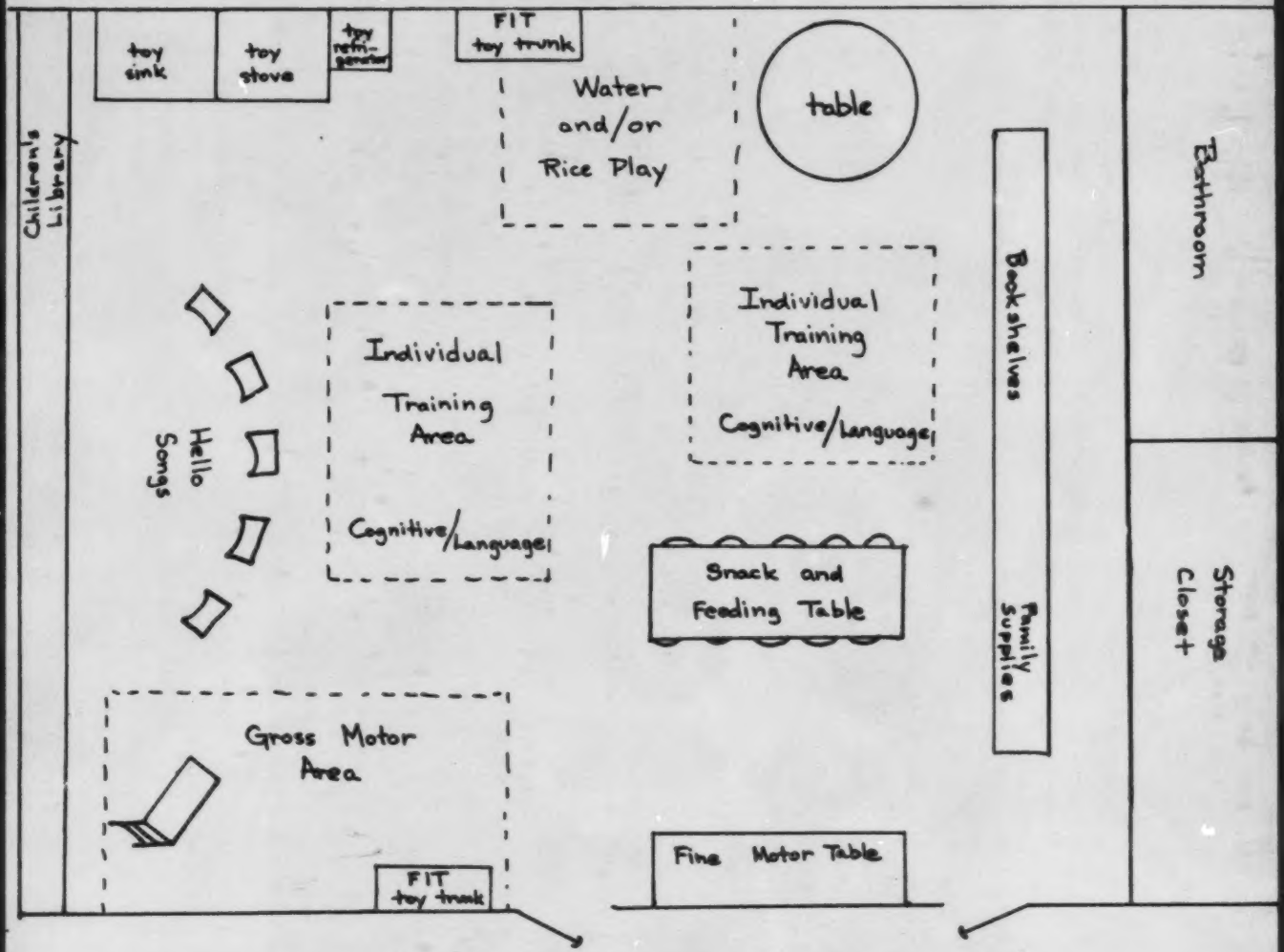
Project weekly meetings. In addition to space, the churches supplied heat, electricity, and air conditioning. The clinics were held in one or two Sunday-school rooms. Individualized training sessions and childrens groups were conducted in rooms that were designed for use by babies and toddlers. The parent groups and the professional training sessions met in adult rooms and in rooms for older elementary children. Teachers and families used equipment and furniture that were available in the rooms, as well as adding a few pieces of large equipment such as a teeter toter, slide, and physical therapy equipment. Trunks or foot lockers provided storage space for small toys purchased by the FIT Project staff. The trunks were locked and stored either in the Sunday-school rooms or in nearby storage space that the churches provided for the Project.

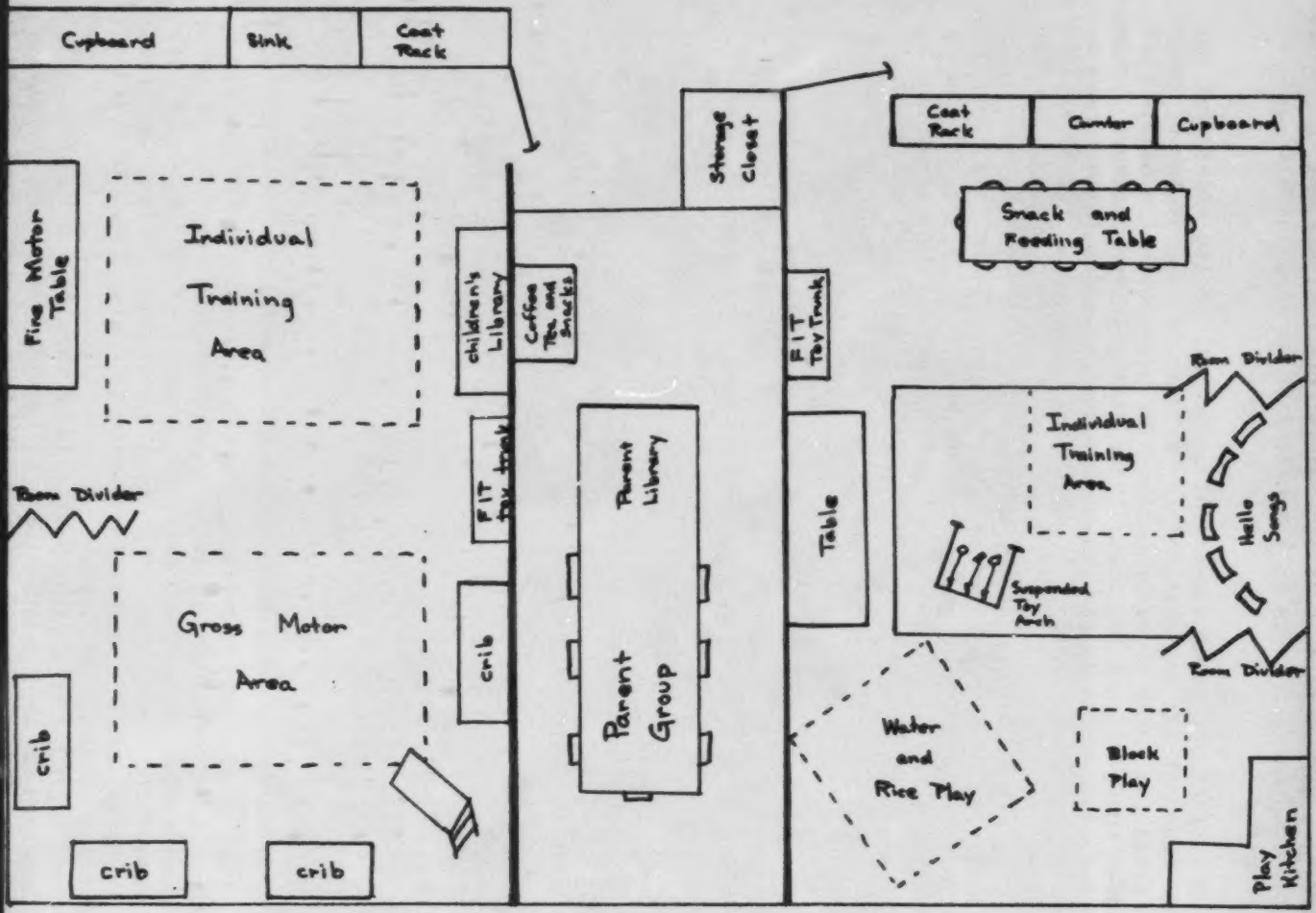
The equipment and furniture that the churches made available to the FIT Project clinics included child-sized tables and chairs, carpets, bookcases, children's toys, and in one case, cribs and high chairs. Bathrooms were located close to the rooms. Church kitchen facilities were used in preparing the snacks and for occasional evening functions such as potluck dinners and open house. Not every church provided appropriate equipment and furniture for the clinics. For example, at one site the clinics were held in a storage room that the church made availble. There, the teachers and families relied completely on FIT Project equipment, supplies, and toys.

Room arrangement. Teachers experimented with a variety of room arrangements at the different FIT Project clinic sites. They planned areas for group time, for gross motor activities, for fine motor activities, for snack time, and for displays of parent library books. When the FIT toys and equipment, along with the churches' nursery toys, left little open space for clinic activities, teachers moved some of the churches' equipment out of the room during the 3-hour clinic sessions. Figure 3 contains two sample room arrangements, one arrangement using one nursery room and another using two rooms.

Parents often worked together in one area sharing the same toys and equipment. On some occasions, parents felt their children were distracted by all the activities of other families and children close by. These parents moved to an unused room or quiet hall for their individualized training sessions.

The Project staff attempted to maintain good relationships with the churches. Staff members were careful to clean up after clinic sessions, emptying garbage cans, straightening rooms, vacuuming, washing dishes, and putting away FIT Project equipment. They attempted to leave the rooms just as the churches had requested. They also informed the churches about clinic activities and checked with secretaries or ministers before scheduling any additional events. For being able to use church facilities, Project staff members expressed the gratitude of all participants in the Project to the ministers and their congregations by sending Christmas and Easter cards, by providing information for the church bulletins, by writing letters to the ministers, and by presenting certificates of appreciation to the congregations at the conclusion of the Project.


toy sink
toy stove
toy refrigerator
FIT toy trunk
Water and/or Rice Play
table
Children's Library
Bookshelves
Bathroom
Storage Closet
Individual Training Area
Cognitive/Language
Individual Training Area
Cognitive/Language
Hello Songs
Snack and Feeding Table
Family Supplies
Gross Motor Area
FIT toy trunk
Fine Motor Table


Cupboard
Sink
Coat Rack
Storage closet
Coat Rack
Counter
Cupboard
Fine Motor Table
Individual Training Area
Snack and Feeding Table
children's Library
Coffee Tea and Snacks
FIT Toy Trunk
FIT Toy Trunk
Room Divider
Parent Library
Individual Training Area
Table
Hello Songs
Room Divider
Suspended Toy Arch
Gross Motor Area
crib
Parent Group
crib
Water and Rice Play
Block Play
crib
crib
Play Kitchen

Equipment and supplies. The FIT Project staff stored supplies at the sites. The supplies included snack foods, positioning equipment, and infant-care materials such as baby wipes, diapers, kleenex, and paper towels. (Appendix F contains a sample list of supplies used at the clinic sites.)

The staff purchased additional equipment for the sites that augmented what already was available. For example, Sunday-school chairs were often too large or inappropriate for preschool-aged handicapped children who could not sit alone. The family/infant teachers purchased educubes, some physical therapy equipment, and a few large toys for developing gross motor skills. (Appendix F contains a list of equipment.)

Toys. Toys were selected on the basis of the functional age levels and abilities of the children at the clinics. For example, toys of different textures and toys that made sounds were important for blind children as well as for all the children to stimulate tactual and listening skills. As new children entered the Project and as children already in the Project manifested new needs, the teachers purchased or made additional toys.

Many of the toys were selected for use in the clinics because of their versatility. Teachers and parents often used the same toys to teach skills in several developmental areas. For example, a small wind-up toy could be used for: (a) skill development in tracking (Did children follow it across the table?); (b) object permanence (When the toy was covered with a cloth, could the children find it?); (c) fine motor skills (Could the children hold the toy and transfer it from hand to hand?); and (d) causality (Did the children give the toy to adults to have them wind it, or did the children look for the winding knob?). Many toys could also be used for various purposes at different developmental levels. For example, children on one developmental level could use a ring of plastic keys as a rattle and on a more advanced level could use them as imaginary car keys.

Parents and teachers used the toys in the individual training sessions, and parents also borrowed the toys to use at home. Toys were a good way to help the children become comfortable in the weekly clinics. During arrival time, children were free to explore and manipulate the toys.

Many of the toys and teaching materials that the FIT Project teachers used were found in local toy and discount stores. Appendix F contains a list of toys and materials grouped by the following curriculum areas: (a) gross motor; (b) fine motor/manipulative; (c) cognitive; (d) language; and (e) self-help. Appendix F also lists toys and materials found in catalogs. Since toys are often found in more than one catalog, Appendix F contains a listing of catalogs appropriate for purchasing toys and equipment. These lists are intended as suggestions and should not be considered complete. Many toys and teaching materials can be made from materials found at home. Appendix F lists five references containing ideas for using household materials to make toys for babies and small children.

Staffing Patterns

FIT Project clinics were staffed by teams of two family/infant teachers who traveled from Nashville, Tennessee, to the clinic locations. They were experienced in the fields of special education, child development, psychology, social work, speech pathology, and vision. Since clinics met only one-half day a week, teachers could work part-time at one or two clinic sites while pursuing graduate studies at George Peabody College. One full-time family/infant teacher coordinated activities among the sites.

Teachers assumed the responsibility of case managers for two or three of the five children served in the clinics. The case managers' responsibilities included:

1. Planning individual training activities for clinic sessions;
2. Preparing activity sheets for new activities for the children;
3. Preparing materials for activities to be taught in the clinics;
4. Teaching parents the new activities;
5. Recording the children's progress on targeted behavior;
6. Maintaining the children's master child files at the Project's office;
7. Maintaining the children's clinic files;
8. Maintaining contact with parents (often by telephone) concerning absences, special events, the children's illnesses, and appointments;
9. Distributing Child Study Reports, physical therapy reports, and requests for information;
10. Writing the children's Individual Education Plans and
11. Maintaining liaison with other agencies who had contact with the children.

In each of the clinics, one teacher assumed the role of clinic manager and took care of the administrative responsibilities at the clinic sites. The clinic managers' responsibilities included:

1. Keeping attendance records;
2. Preparing a master schedule for the clinics;

3. Making necessary arrangements with the churches where the clinics were held, including supplying them with a calendar of OUTFIT Project events and arranging for evening meetings and special events;

4. Taking supplies such as clean bibs, snacks, and paper towels to the clinics; and

5. Writing weekly clinic notes. (These were short, anecdotal summaries of the important events that occurred at the clinic sessions. The clinic notes were kept in the Project's files.)

At each of the clinics, one teacher conducted the parent groups while the other teacher was responsible for the children's groups.

One teacher consistently worked with each family. A generalist rather than a number of specialists was needed in order to provide support for the families and educational planning for the children. A bond of friendship and caring often developed between the families and their case managers. This bond was strengthened by mutual appreciation of and caring for the children who had brought them together. However, teachers were available to consult with each other and to share their particular expertise in order to enhance educational planning for the children.

During the last year of the Project, only one family/infant teacher was available to run the clinics at two sites. These two communities were organizing programs to continue early intervention services. Although families received less individual teacher attention during this time, staffing the clinic with one teacher was a workable solution. The family/infant teachers planned for the individual children, explained activities, supervised the parents teaching their children, and demonstrated at least one activity with each of the children. During the last hour of the clinics, people in the community provided care for the children while the family/infant teacher ran the parent groups. In one community, two high school girls taking a child-care class came to be with the children each week. Built into the training program was the participation of local professionals in the FIT Project clinics. As part of that training practicum, local professional trainees assisted the family/infant teachers during the last hour in the parent groups and the children's groups. They also were available occasionally to run the clinics when the family/infant teachers were engaged in in-service work or were on vacation. One professional volunteered to help in the clinics on a regular basis after completion of the 9-month training program. (Refer to the FIT Training Manual for the details of the training program.)

Practicum students from George Peabody College in special education, in psychology, or in the child development specialist program were sometimes involved in working at the clinic sites. In some instances, they assumed case-management responsibilities with a family for a semester, working closely with and being supervised by the family/infant teachers.

Other practicum students led the parent group discussions under the supervision of the Project Director and a family/infant teacher. The local professional trainees and practicum students gave added dimension and enrichment to the clinics.

Clinic Schedule

Clinic sessions were held one morning a week for 3 hours. The clinic schedules were designed to incorporate individual and group training activities for the family members and their children. (See Table 1 for the clinic schedule.) This particular structuring of the clinic time was influenced by the work done in the Model Vision Project, an earlier federal demonstration project at George Peabody College (Davis, 1980).

The educational clinics began with a 20-minute period of informal greeting and discussion. During the arrival period, the parents and teachers had the opportunity to talk to each other, to exchange information about the events of the last week such as their children's progress, and generally to share information parents considered personally meaningful. Much emotional support was given and received during this time, especially as the parents came to know each other and were able to share similar concerns about their children.

Four 15-minute training sessions were scheduled during the morning events. The first training sessions were group training sessions in which all the children, parents, and teachers participated. All participants gathered into a semicircle around one family/infant teacher who conducted a song time. Several songs, in which certain developmental skills were targeted, were sung during this time. The parents were responsible for facilitating their children's participation during the song time. A spirit of community evolved during this time, as this was one activity that everyone did together.

The remaining three training sessions were used as times for parents to learn or to practice activities that facilitated the development of their preschool-aged handicapped children. A detailed description of this process is included in the subsequent section "Individual Training Sessions." Snack times were scheduled after the individual training sessions. The parent groups and the children's groups were scheduled simultaneously during the last hour of the morning. A more detailed description of these activities also can be found in the following sections.

Individual Training Sessions

The weekly clinic schedule provided for three 15-minute individual parent-child training sessions. During these individual sessions, parents either learned new activities to teach their children or practiced activities they had learned at previous clinics.

New activities. When the teachers presented new activities to the parents and children, they described the procedures in detail and modeled the activities with the children. They also explained what

Table 1

Sample Educational Clinic Schedule

Time	Activities	Activities
9:00 - 9:20	Arrival	
9:20 - 9:35	Group Parent-Child Training Parent-Child 1, 2, 3, 4, 5 Trainers A, B	
9:35 - 9:55	Individualized Parent-Child Training Trainer A - Parent-Child 1 & 2 Trainer B - Parent-Child 3	Parent-Implemented Activities Parent-Child 4 & 5
9:55 - 10:15	Individualized Parent-Child Training Trainer A - Parent-Child 4 Trainer B - Parent-Child 5	Parent-Implemented Activities Parent-Child 1, 2, 3
10:15 - 10:35	Trainer A - Parent-Child 1 & 2 Trainer B - Parent-Child 3	Parent-Child 4 & 5
10:35 - 11:00	Snack/Home Planning Parent-Child 1, 2, 3, 4, 5 Trainers A, B	
11:00 - 12:00	Parent-Family Training/ Discussion Group Trainer A - Parents 1, 2, 3, 4, 5	Children's Group Trainer B - Children 1, 2, 3, 4, 5 Allied Professionals

concepts, principles, or skills the tasks helped the children to acquire, as well as how the activities promoted more sophisticated developmental skills. For example, parents learned that dropping blocks in cans helped children gain increasing control of releasing skills and hand function. This leads to higher levels of fine motor skills such as buttoning and writing. This task also helped the children learn different ways objects related to each other (for example, in the box vs. out of the box) and helped the children to see themselves as the agents who caused the blocks to be placed in the boxes. The teachers also explained ways to do the activities with examples of materials that the parents might use at home. Once the parents understood the rationale for teaching their children particular tasks, they could modify the tasks to fit different circumstances. For example, one mother taught her child to drop toys in the toy box at home. The task could be changed to fit the children's likes and dislikes. For example, the children who didn't want to hold blocks might prefer to drop round beads into the boxes. The tasks could be modified for children with different handicapping conditions. Blind children could be encouraged to drop blocks into metal cans in order to hear the sounds they made.

After describing the activities and their purposes, the teachers demonstrated one or more procedures for teaching the children the activities. Teaching methods included:

1. Graduated guidance - full physical assistance gradually reduced to minimal assistance or verbal prompting, and in some cases to complete independence of prompting;

2. Modeling - demonstrating to the children, then asking them to perform the tasks;

3. Environmental arranging - setting up situations in which the children could participate in the normal course of events. For example, suspending toys over the children's heads for them to hit while they were in a crib; and

4. Verbal or gestural directions - "Point to the shoe."

Before attempting new activities with the children, the teachers might seek input from the parents to determine whether or not the children had ever tried the activities, whether or not the materials the teachers had selected might be appealing to the children, and what physical positions might be best for enabling the children to do the activities. During the demonstrations, the teachers sometimes discovered they needed to modify the activities for the children. If the tasks proved to be too difficult for the children, teachers suggested ways to teach prerequisite skills.

For example, if the children were trying to drop blocks in boxes but had problems with releasing the blocks, they could practice squeezing sponges and squeeze toys, rolling balls, and grasping and releasing many types of objects (Furuno, 1979). If the tasks proved to be too simple for the children, the teachers could make the tasks more

difficult. For example, if the children had no difficulty dropping blocks into boxes, they could try dropping smaller objects through a smaller opening. Parents were more likely to use activities at home (a) that they thought were appropriate for their children, (b) that they understood the reasons for doing, and (c) that both the parents and the children enjoyed doing.

The next step in the teaching procedure was for the parents to try the tasks with their children. The teachers helped with any problems and reinforced the success of both parents and children. The teachers gave the parents home-activity sheets describing the activities to put in their notebooks and gave them any additional handouts available that further explained activities. (See Table 4.) Clinic toys and other materials could be checked out for use at home.

Home use of activities. Either during the initial presentation of activities or during the following week when parents reported the outcome of activities at home, the parents and the teachers discussed ways in which the activities could become part of daily family routines. Some parents were particularly adept at finding ways to practice activities during daily schedules. One child was to do a physical therapy exercise to strengthen the muscles in her feet. She was to practice standing on one foot. The mother incorporated the exercise into dressing as the child stepped into her pants, keeping the child on one foot longer than necessary for dressing purposes and rocking her from toe to heel and side to side. Teachers were excited to see parents begin to recognize and to report their children's generalizations of concepts. For example, one mother had been activating toys in the clinic for her child. When the toys stopped, she waited to see if her child indicated that she wanted the action to continue. The mother later reported that at home her child touched her father's arm to get him to continue turning the Jack-in-the-box. This action showed that the child had begun to understand causality.

Parents differed in their use of the activities at home that were demonstrated in the clinics. Some parents planned structured teaching times with their children. Other parents used the activities in the context of daily routines. Some parents explained the activities to others in the family, including brothers and sisters. Parents made their notebooks with the activity sheets available for family use. Often the activities were used as games for family members to play with the children.

Planning. Since teachers had a limited amount of time to work with the parents and their children in the individual training sessions, they needed to prepare carefully. Preparations included:

1. Thoughtfully choosing activities and reviewing the rationale for their selection and use;

2. Preparing activity sheets prior to the clinic session;

3. Planning clinic schedules taking into consideration the best times for different activities. (For example, did the children need activities that required movement alternated with sitting activities? Were there activities that were best for the children to do during the first training session?); and

4. Collecting materials and placing them where they would be easily available during the individual training sessions.

Careful planning was crucial for smoothly running clinics. It was amazing how busy the clinics became for the teachers. Upon the arrival of the parents and children, teachers had adults to greet, events of the week to hear about from parents, and children with whom to talk. The clinics were social occasions as well as learning and teaching times. The teachers needed to balance carefully the building of support systems with the learning function of the clinics.

Snack times. Thirty minutes were set aside during each clinic session for snack time. These periods provided needed breaks for relaxation and for socialization for the parents and children, while providing a setting for additional training in feeding and language skills.

During snack times, parents, teachers, and children sat together around a large table. Parents chose beverages and food for themselves and their children from supplies furnished by the clinic. At one site snacks were furnished by professionals in the community involved in the training program. Parents were given a chance to relax and talk with each other while they helped their children with their food. Specific feeding goals and activities were set by parents and teachers for the children based on their needs. These activities were reviewed with parents for a short time during the snack time. Activities focused on such things as: (a) inhibiting abnormal reflexes; (b) facilitating lip closure; (c) jaw control; (d) chewing; (e) encouraging independent finger and spoon feeding and cup drinking; and (f) providing proper positioning for the safest, most effective feeding of the handicapped children. Language-stimulation activities appropriate to the children's abilities were also stressed. For some of the children, this involved merely talking and socializing with them while they ate. For other children, specific activities were used to promote receptive and expressive language skills. For example, one child had to hand her cup to an adult on verbal cue in order to get her juice, while another child was required to vocalize rather than merely gesture in order to receive a snack.

Because all of the parents and children were gathered together during snack times, the parents were able to remark on the children's progress and commiserate their occasional failures. Snack times also became times for the parents to discuss problems and fears related to feeding such as children's refusal to eat most foods or problems with children not gaining weight. They were able to offer each other suggestions and remedies to alleviate many of these problems.

On one occasion, several of the parents discussed their difficulties in getting their children to drink liquids. They all discussed various means of thickening the liquids to make them more drinkable for the children. On the basis of that discussion, each parent brought one ingredient to the clinic the next week and blended a nourishing and tasty milkshake for the children to drink during snack time.

Parent groups. The last hour of the weekly FIT Project clinics was devoted to parent groups. The purposes of the groups were to provide parents with basic information about child development, child rearing, and teaching strategies as well as to provide parents with opportunities for discussing problems, sharing experiences, and building support among their peers.

Parents met in rooms where a coffee pot was set up with hot water for coffee, tea, and hot chocolate. The children remained in a clinic room for the children's group. Separation was a problem for a few parents and children, especially if the 1 hour parent group was the only time they were away from their children.

Other parents came to the parent-group room with sighs of relief. They looked forward to the hour when they could relax and enjoy talking with adults who shared similar experiences.

One parent/infant teacher led the group. The teacher selected the topics for discussion based on the parents' suggestions and the needs of the group. The format for the parent groups varied with the topics planned for presentation. Discussion was the format used most often. Films, videotapes, speakers, activities such as toy making, presentations, field trips, and discussions built around open-ended questions were planned from time to time.

Information concerning child development in fine motor, gross motor, self-help, language, and cognition helped parents build a framework for understanding the importance of activities they were learning in the clinics. In typical parent-group sessions, teachers made brief presentations about one developmental area with additional information provided in handouts. Teachers asked questions to help the parents understand how handicapping conditions influenced different developmental areas. Since the groups were small, parents were able to discuss their concerns about their children's development in particular areas. The groups spent time discussing how to teach the children skills in specific developmental areas and how to promote development of those skills in the homes. For example, when children anticipate having their shoes put on, mothers can quickly put them under a pillow with a small portion protruding. This exercise begins to teach object permanence. Parents shared with the groups teaching techniques that had worked for them.

Child management issues almost always came up during discussions. The groups were able to help families experiencing particular problems on several occasions. In such situations, teachers helped parents share

solutions that had worked for them in similar circumstances by encouraging parents to make suggestions and by supporting their ideas concerning possible solutions.

Parent/infant teachers planned times for discussing family concerns, including reactions of families to having handicapped children and the needs of individual family members. Sometime during the parent group sessions, parents usually wanted to tell their stories about their children's difficulties and about how they came to discover that their children were handicapped. They sometimes expressed the view that in the FIT parent groups people understood what they had been through. Understanding family histories was an important ingredient to building a sense of community among the group participants.

The parent-group participants surveyed available services for preschool-aged handicapped children in their communities. They visited public school classrooms the children might attend, invited speakers to discuss wills and trusts, learned about infant tests, and discussed how to work with professionals.

The topics used for parent groups during the 3 years of the demonstration project are included in Table 2. They are grouped under the following headings: (a) Child Development and Child Rearing of Children with Special Needs; (b) Teaching Issues; (c) Family Issues; and (d) Special Issues for Families with Children with Special Needs. The Project staff prepared a Parent Group Manual to assist parent group leaders in running parent groups. Twenty-two of the topics have been developed into modules that include sections on: (a) objectives; (b) sequence of the sessions; (c) ways to begin; (d) background information for the leaders; (e) questions to continue the discussions; (f) conclusions; (g) next steps; and (h) bibliography.

The Project staff provided parent libraries at the sites. The libraries contained small collections of books with topics on child development, learning experiences for children, parenting, and handicapping conditions. There were also a few children's books. (A bibliography of the books is in Appendix G.) Before and after parent groups, parents had time to look over the books and make selections. Some parents liked checking out the books while others showed little interest in them. Teachers sometimes recommended books during the parent groups, during individual training sessions, or when parents expressed particular interests or concerns. Parents who usually did not check out library books often would check out specifically recommended books, though.

The parent groups were essential components of the FIT clinics. They provided information for parents and possible solutions to problems that they faced. During the parent-group sessions many parents freely described their experiences, feelings, and hopes for their children. Parents gained support from each other and from the knowledge that others had similar experiences and feelings. They expressed interest and concern for each other and for each other's children.

Table 2

Parent Group Topics

Child Development and Child Rearing of Children with Special Needs

- Children's Emotional Development Leading to Independence
- Children's Thinking Skills
- Components of Learning
- Feeding Problems
- Feeding Techniques for Down's Syndrome Children
- Language Development
- Motor Development
- Spoon Feeding
- Strengthening Children's Self-concepts
- Teaching Self-help Skills

Teaching Issues

- Behavior and Discipline
- Christmas Toys
- Educational Goals for Your Children
- Mothers as Therapists
- Negative Behavior in Children
- Parents as Teachers
- Peer Interactions
- Public Law 94-142
- Reinforcement
- Rules of Talking
- Sensory Stimulation Part I - Book Making
- Sensory Stimulation Part II - Making Toys for Feeling and Hearing
- Teaching through the Senses
- Teaching Your Children through Play

Family Issues

- Acceptance of Your Children's Handicap
- Brothers and Sisters of Handicapped Children
- Fathering
- Feelings about Our Handicapped Children
- Parent Needs
- Separation
- The Handicapped Child in the Family
- "Today Is Not Forever" - videotape*

Special Issues for Families with Children with Special Needs

- A Public School Class for Handicapped Children - speaker
- Advocacy
- Answering People's Questions on Handicapping Conditions
- Description of Community Services for Handicapped Children
- Field Trip - Developmental Center
- Functions of Parent Groups
- Infant Tests
- Least Restrictive Environment
- Mental Retardation
- Obtaining Babysitters for Your Handicapped Children
- Organizing and Keeping Child's Records
- Seizures
- Understanding Professional Reports
- Vision
- Wills, Trusts, and Guardianships - speaker
- Working with Professionals
- You as Your Child's Representative

*Available from Intersect, 1101 17th Avenue South, Nashville, Tennessee 37712.

Children's groups. While the parents went into another area of the clinics for parent's groups, the children remained in the classrooms for children's groups. Children's groups were essentially periods for supervised individual and group-play activities. Because of the wide range of developmental and chronological age levels and the types of handicaps within the groups, actual group activities were very difficult to carry out. Therefore, individualized or very small group activities often were more successful than large groups with the children. More than one adult was needed to supervise these activities.

During many children's group sessions, local professional trainees came into the classrooms and practiced assessing, developing, and implementing individual activities with the children. These sessions were very helpful to the teachers. The teachers could see how the children responded to new activities in a more leisurely setting than the normal clinic schedules provided. These sessions also provided the children with individualized attention from someone other than their parents and teachers.

When the local professional trainees were not available for the children's groups, a teacher and a volunteer (a relative of one of the parents or an interested person from the community or church) usually would oversee the session. The two adults positioned the nonambulatory children close to each other with appropriate toys. The ambulatory children were allowed free-play time or were engaged in group activities such as "Ring Around the Roses." Whenever possible, ambulatory and nonambulatory children were involved in activities together. For example, during one clinic session two children who were learning to walk took turns pushing a nonambulatory child in a buggy with a teacher's help.

On clinic days when no volunteer or professional trainees were available, one teacher supervised five children. The teacher engaged several children in free-play activities while working with one or more other children at a time. In this situation, the planned educational activities almost were impossible to implement.

Children's groups changed from week to week to accommodate the needs of the parents, the children, the teachers, and the local professional trainees involved in the Project. While the children would not always receive additional instructional time in the children's group, they were able to be together and to be away from their parents.

Evening Family-meeting Schedule

The evening family-meeting clinics were held every 6-to-8 weeks and were designed to involve extended-family members with the education of the preschool-aged handicapped children. The objective of the evening family meetings was to assist the extended-family members in supporting the nuclear-family members in dealing with their handicapped children. This objective was achieved by providing specific information about their handicapped children; by informing extended-family members about ways they could help the parents, and by assisting extended-family members cope with the frequent emotional crises surrounding the birth of handicapped children.

The format of the evening family-meeting clinics was a modified version of the daytime clinic schedule. (See Table 3.) The evening clinics lasted 1-3/4 hours and included individual and group training activities and group discussion periods.

The initial 20 minutes was an unstructured arrival time during which the family members met and renewed acquaintances, had informal discussions, and looked at the clinic facilities and materials.

Three 15-minute training sessions were scheduled during the evening. As in the daytime schedule, the first training session began with a group song. All participants gathered into a semicircle around one family/infant teacher who conducted the song times. The same songs that were sung in the daytime clinics were also sung in the evening clinics.

The two remaining training sessions were used to teach extended-family members specific activities that were part of the children's educational programs. As in the daytime clinics, the family/infant teachers demonstrated particular activities and explained the purposes and goals of the activities. The family members were encouraged to participate by practicing the activities with the children under the guidance of the teachers. All family members were encouraged to use the home activity sheets or handouts that described the goals, purposes, and procedures of individual activities.

Following the training sessions, the family members and teachers met together for family discussion groups. The family discussion groups were conducted similarly to the parent groups in the daytime clinics. Family members were presented with general information about mentally retarded children and their development. This also was a time in which they learned constructive ways of thinking about mental retardation and dealt with their emotional reactions to having retarded children in their families.

The handicapped children and their siblings stayed in separate rooms during the family discussion groups. Babysitters from the community cared for the children during this time.

Extended-family members initially grouped themselves with their own families during the evening family-meeting clinics. As the people became more familiar with one another there was more discussion among them regarding their handicapped children. The interactions among the families emerged slowly, however. Perhaps the length of time between meetings and the discussion topics influenced the frequency with which families interacted. The families may have considered the discussion topics too private to share with each other.

The family/infant teachers considered the needs of the extended-family members in planning the activities that were presented at the evening clinics. Often, the parents were consulted for their choices of the activities. For example, a grandfather of a preschool-aged multihandicapped girl was not able to lift her. Her mother reported that his main activity with his granddaughter was holding her on his

Table 3

Evening Family-meeting Schedule

Time	Activities
7:00 - 7:20	Arrival
7:20 - 7:35	Training Session
7:35 - 7:50	Training Session
7:50 - 8:05	Training Session
8:05 - 8:45	Family Group

lap and talking to her. Therefore, the teacher chose positioning and language activities for the grandfather to use with his granddaughter so that he could teach her in a way that was familiar to him.

With the greater number of family members present with each of the children, the children sometimes would be distracted from the activities that were being taught. Often, though, the children received additional praise and some enjoyed the captive audience while they completed their activities. For example, one child with spina bifida had been unable to tap two blocks together until her mother, aunt, and babysitter demonstrated the task and praised her efforts.

Not all of the extended-family members regularly carried out the activities that were shown during the training sessions. It was difficult for the teachers to insure followup of the activities with the 6-to-8 week time lag between meetings. But the clinics did provide a valuable springboard for extended-family members to learn which activities facilitated their children's development. Prior to attending the clinics, some extended-family members did not understand the activities the parents were teaching their children in their homes. By attending the clinics, they heard the rationale for the activities and participated in them in the clinic setting. Thus, the extended-family members were more likely to have positive views toward the intervention. This provided valuable support to the parents.

The extended-family members were encouraged to be supportive in other ways, also. For example, offering to babysit periodically is an important contribution to parents with handicapped children.

Home Visits

Although the FIT Project was a center-based program, teachers found that periodic visits in the homes added a valuable dimension to the educational program. By seeing the physical environments in the homes, seeing the children's routines, and seeing what materials and equipment were available for the children to work with, the teachers had a better understanding of the children's lives and could better plan activities. FIT Project teachers visited the families approximately every three to six months. Home visits typically lasted 1-1/2 to 2 hours.

Sometimes parents found that their children would do some activities at home that they would not perform at the clinics. Home visits gave the teachers an opportunity to see the children complete those activities. For example, a blind child who had not taken any independent steps at the clinic took several steps between two familiar objects at home. Teachers also saw some self-help activities more easily as well as the children's level of independence in the homes.

Teachers observed the patterns of interaction between mothers and their children or among the fathers, mothers, and their children and any brothers and sisters who were present during the home visits. Some members of the family could attend only home-visiting sessions. Sometimes, family dynamics in the homes were very different from those in the clinics.

During the home visits, the teachers and families had more uninterrupted time together than at the clinic sessions. The teachers conducted assessments of the children, tried out new activities, and spent time getting to know the children and parents. Many times parents felt more comfortable discussing personal problems at home than they did at the clinics. Since there was no schedule and no interruptions, conversations could flow freely from one topic to another. Parents had time to show photo albums and tell more about themselves and their families.

Liaison

Many of the children receiving services in the FIT Project clinics received additional medical and educational services from other agencies. For example, children were seen by neurologists, audiologists, orthopedic surgeons, and pediatricians in addition to attending the FIT Project clinics. To decrease the possibility of children receiving "splintered" services, the FIT Project staff provided liaison services between the families and the agencies and between agencies.

Case managers for the families were the persons responsible for liaison activities. After parental permission was obtained, the case managers routinely requested copies of reports from other agencies involved with the children. The information gathered from the agencies provided valuable information to the case managers in planning the educational goals for the children. Information gathered from agencies also was discussed with the parents.

If additional services were needed or if services needed to be coordinated, case managers, with permission from the parents, contacted the proper sources in order to discuss the situation.

Informal efforts were made by the case managers to keep in periodic contact with the professionals involved with the children. The case managers also sent the evaluation reports and physical therapy reports to the children's pediatricians. Pediatricians were consulted if referrals for additional services were needed. When children left the FIT Project and went to other programs, the case managers sent the Individual Educational Plan and progress reports to those programs.

The local professional trainees in the training program were an important liaison component of the FIT Project clinics. These professionals represented various agencies in the communities and often were consulted when additional services were needed for individual families. They were familiar with the resources in the communities and the services they provided. In one case, a local professional trainee collaborated with a parent from the FIT Project clinic to arrange for physical therapy services for FIT Project children who needed these services.

In coordinating services with other agencies for children participating in the clinics, local professionals not only learned about FIT Project services but about other services needed by preschool-aged handicapped children and their families as well. Liaison activities promoted

community awareness of the FIT Project, and community involvement with the children and families, and enhanced the possibilities for Project continuation after the termination of federal funds.

Program Planning for Families

Planning for Initial Clinic Sessions

When families entered the Project, the first two or three clinic sessions were designed for families and teachers to get acquainted with each other and for families to familiarize themselves with the clinic activities. Many times, family experiences prior to the FIT Project clinics were negative ones. Professionals often suggested that their handicapped children be institutionalized when families did not want to consider institutionalization; or the primary activity was one of labelling the children's problems rather than suggesting ways to deal with the problems. For most parents, the FIT Project was the first intervention or school experience that they and their handicapped children had ever had. The initial clinic experience often provided parents with their first visible models for behaving positively and constructively with their children (Davis, 1980).

For the teachers, this initial period was a time to find out the immediate concerns of the families. Families frequently came to the initial session with problems for which they wanted immediate solutions. This information often was gathered by asking the parent "What is the first thing you want your child to learn?" Therefore, the first activities that were demonstrated usually addressed such immediate concerns of the families as eating problems, positioning problems, or behavior problems.

After the teachers developed some familiarity with the children and their families, they planned activities for the weekly clinics based on priorities and special concerns of the families and on observations of the children's developmental levels, special needs, and parent-child interactions. Teachers initially chose activities that were fun and were likely to be successful immediately for the parents and children. This success reinforced participation in the activities.

The parents also received entry packets the first day of attendance. The packets typically were distributed during the arrival time or during the training sessions. Teachers explained the information included in the entry packets at the time of distribution.

A core of handouts was included in the entry packets. Additional handouts were included if they were appropriate to children's specific disabilities. (A brief description of the handouts and information regarding where they could be obtained are contained in Appendix H. A sample copy of many of the handouts is also included in Appendix H.)

Physical Therapy Evaluations

Many of the children in the FIT Project clinics were delayed in their motor development. A pediatric physical therapist evaluated the children twice a year and prescribed activities for the teachers and parents to include in the children's educational programs.

Before the physical therapist saw the children, the parents obtained a doctor's prescription for the children to receive a physical therapy evaluation. Copies of the physical therapy reports were sent to the doctors following the evaluations.

On the day of the evaluations, families had one-hour appointments with the therapist at the clinics. These one-hour appointments replaced the clinic schedule for that week. The therapist spent some time getting to know the children and winning their cooperation. Sometimes the children resisted the evaluations, but the therapist gathered enough information about their motor abilities to prescribe activities.

The therapist determined the children's levels of motor development using the Gesell Developmental Schedules (Gesell, 1949). She looked to see which primitive reflexes the children had integrated and if the primitive reflexes were inhibiting the children's motor development. She looked to see if the reflexes needed for more advanced development were emerging. She tested the children's muscle tone, equilibrium reactions, quality of movement, rotation patterns, and fine motor skills. Throughout the evaluations, the therapist used the equipment normally available in the FIT Project clinic. She demonstrated to parents and to teachers each activity she suggested for improving the children's development and explained how the exercises would help the children. Whenever possible, the therapist chose exercises that required the children to move or adjust their movements rather than passive exercises someone applied to the children. The teachers and parents usually had an opportunity to try the exercises with the children while the therapist supervised.

Feeding demonstrations were done with most of the children. The therapist evaluated chewing motions, lip closure, sensitivity around the mouth, and tongue movement. She suggested ways for improving muscles around the mouth, for tongue control, and for chewing motions.

The therapist wrote one-page evaluations and suggested 9-to-12 activities to use with the children during the next 4-to-6 months. The evaluation reports were sent to the FIT family/infant teachers who distributed them to the parents. Teachers reviewed the reports with the parents and helped them practice the activities in the clinics. (An example of a physical therapy evaluation and activities is included in Appendix I.)

Individual Educational Plan Meetings

After the children were enrolled in the Project for approximately 3 months, the children's case managers scheduled Individual Educational Plan meetings. At the Individual Educational Plan meetings, the parents

and teachers discussed goals they hoped the children would achieve in the next 6 months. These goals were based on the results and recommendations of the psychoeducational evaluations, the informal observations of teachers, the families' priorities for their children, and the physical therapy evaluations. After these meetings, the teachers wrote the Individual Educational Plans, met with the parents to discuss the objectives, and gave the parents copies of the Individual Educational Plans. Copies of the Individual Educational Plans were kept in the Master Child File and in the children's clinic notebooks.

Individual Educational Plan. The teachers wrote the children's Individual Education Plans to state clearly the goals that the parents and teachers planned to implement with the children during the subsequent 6 months. Individual Educational Plans were updated, or rewritten if needed, every six months. (A sample Individual Educational Plan is included in Appendix J.) Each Individual Educational Plan form included the following information:

1. Child's name;

2. Case manager;

3. Date the Individual Educational Plan was written;

4. Clinic site--which location the children participated in the Project;

5. Current developmental status of the child--The teacher stated the children's level of performance in the domain(s) for which the objectives were written based on test findings and current developmental assessments. When behavior was described in conceptual terms, specific examples were included in order to illustrate the concepts. For instance, "Susan repeats actions that produce results she enjoys. For example, she shakes a rattle to hear the sound and see the movement.";

6. Developmental intervention areas--The targeted developmental areas were underlined or circled. Since objectives can target several related developmental areas, on many occasions more than one developmental intervention area was underlined. These developmental areas were derived from the Uzgiris-Hunt Scales, Griffith Scales, and Nonverbal Communication Scale compiled by Carl Dunst;

7. Long range goals--general statements of what the children were expected to learn in a particular domain as a result of their educational program during a 6-month period. To be both reasonable and attainable, the teachers based long-range goals not only on the children's developmental status, but also on what the children could be expected to achieve based on their previous developmental histories. In some cases where development was extremely slow, goals

might be the refinement and practice of present and emerging skills rather then the acquisition of new skills;

8. Short-range objectives--specific statements of which skills, within a domain, that the children should acquire over a 6-month period. Evaluation criteria, date of initiation, projected date of attainment, and actual attainment date information was also included for each objective.

Reassessment

The children had formal reassessments annually and upon exiting the program. The formal reassessments consisted of the procedures described in the Evaluations Procedures section.

The Project staff also conducted informal educational reassessments, using the Griffith's Scales and the Uzgiris-Hunt Scales. These assessments were conducted either during regularly scheduled clinic sessions, during children's groups, during home visits, or during scheduled appointments in which usual clinic activities were cancelled. Occasionally the reassessments were given by professionals in the training program as part of their practicum experience under the supervision of FIT teachers. Short term changes were monitored on the Home Activity Sheet and the Individual Educational Plan records.

Teachers noted progress and problems as they observed parents working with their children during the weekly clinic sessions. Also, during clinic sessions, parents reported what had worked and what had not worked at home. Case managers often consulted with the other teachers at the clinics as well as with other FIT staff members concerning program planning issues. Time spent traveling to and from the clinic sites afforded excellent opportunities to discuss at length the progress and problems of individual children and the best approach for working with the children and their families. Thus, program planning and reassessment was a continuous process with input from many sources.

Curriculum Usage

Rather than developing a curriculum specific to the FIT Project, the FIT Project staff utilized existing curricula in the special education field that corresponded to the Project's philosophical and theoretical considerations in planning educational programs for preschool-aged handicapped children and their families. In this way, staff members were not locked into a specific list or set of intervention activities for all the children. Instead they were able to develop individualized intervention packages for the children based on the needs, abilities, and limitations of the children and their families.

The family/infant teachers consulted many curricula to develop individual program plans depending on the physical and/or sensory handicaps of children. A number of existing resources proved to be extremely useful in describing modifications in positioning and the environment and in developing activities for children with specific handicaps. These

sources were compiled by Carl Dunst (1981) into a Curriculum Matrix entitled An Early Childhood Intervention Curriculum Matrix. This grid indicated primary and secondary sources for intervention for children up to 4 years old. This resource is available through the FIT Project.

The framework for devising intervention packages, after the teachers consulted various curricula, was described by Carl Dunst (1981) in Infant Learning: A Cognitive - Linguistic Intervention Strategy. In this manual, Dunst described an intervention in which the children first were assessed using the Piagetian framework in order to determine levels of functioning within several developmental areas. Intervention packages were developed on the basis of this assessment. A primary premise of developing such intervention packages is that infant cognitive-linguistic development is not merely additive, that is, it does not accumulate through mere maturation nor through simple stimulus-response behavior chains. Instead, each previous stage of development and the behavior of functioning at that level are incorporated and reorganized into higher level, qualitatively different stages.

In incorporating this premise into the development of intervention packages for children, it was necessary to view the children as developing specific concepts (for example, increasingly mature levels of object permanence), rather than mere skills (for example, uncovering a toy hidden under one screen). The children's present levels of functioning were targeted and a wide range of activities was provided to strengthen and broaden the children's abilities to perform in the various domains at one level, while working toward attainment of higher stages of development. Activities were sometimes developed as formal learning tasks, but more often were suggested as play activities or incorporated into the children's daily routines (for example, hiding the child's cup behind his napkin at breakfast to develop object permanence).

The use of the Curriculum Matrix allowed the teachers to work freely within the framework of the needs and abilities of the families and their children. Individual objectives and activities were developed for the families, allowing for differences in educational levels, financial resources, and available time and energy for working with the children. In this way, the parents with limited resources and support systems were not pressured to work with the children in ways that were beyond their individual capacities.

Record Keeping

Master Child File

Case managers maintained a master child file for all the children located in the Project office. These files contained all the reports the Project staff had obtained regarding the children and information regarding the FIT Project's involvement with the children and their families. Teachers used the files in order to find out specific information about the children they were teaching. The evaluation teams used the files to become familiar with the children they were evaluating.

Reports stored in the master child file were sent to agencies that had obtained permission from the families for specific information. Persons other than those who usually worked with the children were required to sign a file sign-out sheet before reading the files.

The master child file contained the following information:

1. Identifying information--including child's name, birthdate, parent's name, address, phone number, and parents' employment;

2. Service plan--including date, problems that needed to be addressed, plans to ameliorate the problems, and present status of the problems;

3. Permission forms--including permission for the child to receive a psychoeducational evaluation, consent for photographs, permission to request information about the child from other agencies, permission from the child's doctor for the child to receive a physical therapy evaluation, and permission forms from agencies requesting information about the child;

4. Referral letter--from the person who referred the child to the FIT Project;

5. Screening report--of the FIT staff member's visit to the family to determine the child's eligibility for the FIT program;

6. Evaluation reports--including all psychoeducational evaluations, protocols of assessment instruments, and physical therapy evaluations;

7. Teacher summary report--summarizing child progress, attendance, parent involvement, major concerns, and placement.

8. Exit interview--report of parents' reactions to their experience of being involved in the FIT Project;

9. Individual Educational Plans--with information regarding progress toward attainment of goals;

10. Agency reports--from doctors, clinics, and other providers who had seen the child; and

11. Communications Records--including letters, notes, and telephone calls that involved the family.

Attendance Records

One teacher in each clinic kept records of the children's attendance at morning clinics and at family evening-clinic sessions. Teachers asked parents to notify them when they were going to be absent. When children were absent three consecutive times without notification of the teachers by the parents, the teachers contacted the families to see if there were

problems they needed help with and if they were still interested in having their children in the Project. Continued unreported absences resulted in the children being dropped from the Project,

Considering how often small children with handicapping conditions are ill, attendance at the clinics was excellent. During the 3 years the Project operated, attendance ranged from 59 percent to 65 percent.

Clinic Notes

One teacher at each clinic wrote anecdotal reports to document the events of the clinic sessions. These reports were stored in the Project's files. Some teachers dictated these notes while traveling from the clinic sites to the main FIT Project office. The reports included a list of everyone present and the highlights of the sessions. Teachers wrote about special achievements of the children as well as disappointments that parents experienced. The anecdotal style of the reports gave a feel for each clinic session as seen through the eyes of the teachers. These notes were used in the preparation of the documents that the OUTFIT Project staff uses in their dissemination efforts.

Parent Group Notes

The group leaders of the parent groups wrote or dictated reports of each group. These also were kept in the Project's files. These reports included the names of everyone who attended, the topics for discussion, brief summaries of the presentations and discussion questions, and comments on the process of the group sessions. Copies of the handouts distributed by the group leaders also were included. Parent group reports often were useful to parent group leaders in other clinic sites who were planning to discuss the same topics with their groups. The notes were a useful reference for new group leaders so that they could review the events of the previous group sessions. The parent group notes were used in the preparation of the documents that the OUTFIT Project uses in their dissemination efforts, also.

Clinic and Parent Notebooks

The clinic and parent notebook concept was developed out of the need for teachers and parents to have an organized collection of educational information about each of the handicapped children. The notebooks contained evaluation and intervention information. Both the parents and the teachers kept copies of the notebooks. The parents were responsible for their copies of the notebooks, and the case managers were responsible for the clinic copies of the notebooks.

The clinic and parent notebooks were three-ring binders that were subdivided into six sections. The first section contained the schedules for the FIT Project clinic sessions. These schedules, which listed the activities planned for the clinics that day, were given to the parents at the beginning of the sessions.

The subsequent four sections contained developmental intervention information. These four sections were labeled (a) gross motor; (b) eye-hand/manipulation; (c) language/cognition; and (d) personal/social. (The intervention areas were subsumed under these four main domains.) Each of these sections contained activity summary sheets and home activity sheets that were appropriate for that particular skill area.

The last section of the notebooks was the evaluation section. The physical therapy reports, the initial psychological and educational evaluations, the yearly reassessments, and the Individual Educational Plans were kept in this section. Both the teachers and the parents had easy access to this information during the clinic sessions and at home.

Most of the parents liked having personal copies of the notebooks. One parent commented that she would not trade her notebook for $1,000. Some parents also reported that other family members referred to the notebooks when they wanted to know which intervention activities were being taught in the clinics and how to implement particular activities with their children. However, some parents referred to their notebook infrequently. These parents preferred to be shown how to do activities rather than to read instructions on the activity sheets. They also preferred to demonstrate the activities to the teachers when they returned the next week rather than to report the results on paper. These parents were allowed to use their preferred style in the clinics. The teachers tried to be sensitive to the learning styles of the parents and to reinforce appropriate intervention methods parents used with their children.

Activity Sheets

Each week the FIT Project teachers prepared activity sheets that described new activities they planned to teach the children and their parents. The parents referred to these activity sheets when implementing the activities both in the clinics and at home. Home activity sheets included information regarding the materials needed, the procedures, and the rationale for the activities. They also included charts to keep track of the children's progress with the particular skills that were being targeted. Either the teachers or the parents filled out the charts after the activities were completed in the clinic. (See Table 4 for a sample activity sheet.)

Activity Summary Sheets

Activity summary sheets were provided for each developmental area. These summary sheets listed all the activities for meeting specific developmental goals that the teachers had planned. A grid provided space to record, by dates and check marks, when parents worked on the activities outside the clinic sessions. When activities were no longer appropriate, usually because the children had mastered them, a plus (+) was recorded on the grid. The summary sheets were designed to help parents understand the purposes and interrelationships of the activities. They also enabled teachers to see which activities parents used at home and which activities they did not do at home. (See Table 5 for a sample activity summary sheet.)

Table 4

Sample Activity Sheet*

Name of Child Chris Jones

Date March 17, 1980

Family, Infant and Toddler Project
Peabody College of Vanderbilt University
Nashville, Tennessee 37203

Activity #1 Grasping a small object

Chris picks up an object with thumb and tip of middle or index finger							
Chris uses her thumb and first two fingers							
Chris uses her whole hand							
Chris wasn't interested today							

Comments:

Activity #2

Comments:

*Adapted from Learning Activities for the Young Handicapped Child.

**The names mentioned in have been changes to protect confidentiality of the participants in the FIT Project.

ACTIVITY: Grasping a small object.

WHAT YOU WILL NEED: Small objects such as cereal, string, pegs and tape.

HOW TO DO THE ACTIVITY:

1. Place double stick tape between Chris's thumb and first and second fingers and have her pull her thumb away.
2. Demonstrate opposing the thumb to the first two fingers. See if she will imitate you.
3. Have Chris pick up objects using her thumb and first two fingers. (Guide her hand with the last two or three fingers curled in her palm.) Be sure she doesn't put any non-edibles in her mouth.
4. Have Chris pick up small edibles such as raisins and cereal.
5. Place a tiny object in a cup or egg carton to encourage Chris to grasp it with her thumb and index finger.
6. Place a colorful piece of string on the carpet or table where she can grasp it with her thumb and index finger.

WHY: To help Chris use her hands and fingers more effectively so that she can feed herself and get things she wants.

ACTIVITY:

WHAT YOU WILL NEED:

HOW TO DO THE ACTIVITY:

WHY:

Table 5

Sample Activity Summary Sheet

Child's Name: Chris Jones Site: Lewisburg

Case Manager: Elizabeth Gerlock

Long Range Goal: Chris will be able to coordinate hand movements to get what she wants

Short term objectives and/or activities:	Dates Checked
9/17/79 Swiping at toys game	✓ +
12/3/79 Two hands with large object	✓ +
12/3/79 Small object in each hand	+ +
1/7/80 Transferring objects	+ +
2/11/80 Pulling out pegs	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
2/25/80 Manipulating two objects at once	✓ + +
3/17/80 Picking up small objects	+ ✓ ✓ ✓ ✓ +
4/7/80 Cubes in a cup	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
4/21/80 Poking or pointing at objects	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
6/9/80 Imitating scribbling	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
6/23/80 Taking the ring stack apart	✓ ✓ ✓ ✓ ✓ ✓ ✓
6/23/80 Unwrapping a toy	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
7/28/80 Dumping to remove objects	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
8/25/80 Turning the pages of a book	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

✓= parent implemented + = child mastered

Finding time for recording the children's progress on the activity sheets and the activity summary sheets was a problem. When parents first came into the program and had only a few activities to implement, they often kept the records at home. Later, both parents and teachers neglected the record keeping. To alleviate this problem, the first part of the parent-group meetings were devoted to updating both the parent and clinic notebooks. Parents recorded the activities they had implemented during the week on the activity summary sheets in both notebooks. They read any comments the teacher wrote on the activity sheets about the children's performance during activities in the clinics. Parents also recorded in the clinic notebooks any comments they may have written at home about an intervention.

Providing time for parents to record completed activities helped solve the problem of record keeping. Many activities were designed to become natural parts of the interaction between the parents and their children or part of the children's environment (for example, the way parents carried their children, positioned them, fed them, talked to them, and played with them). Taking time to check activities at the clinics reminded parents of which activities they actually did at home as well as which intervention activities they may have forgotten to implement.

Appendix A*

Sample Referral Letter

*The names and places mentioned in the appendices have been changed to protect confidentiality of the participants in the FIT Project.

Appendix A

Sample Referral Letter

Re: Child's Name: LaShanda Smith
Birthdate: 10/1/81
Parents' Name: Brenda Smith
Address: 14 Elm Street
Bakersville, Tn.

Dear Ms. Gerlock,

This child has been followed in our Well Baby Clinic since birth. He is also seen on a regular basis by Dr. Petrusek in Bakersville. It was observed early that he may have a birth defect. The private physician expressed to the mother that the child was developing slowly and that there were things that can be done to help the child. The growth curve is below normal for an infant this age.

Sincerely,

Ann White
Public Health Nurse

Appendix B

Initial Contact Letter to Families

George Peabody College for Teachers
VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37203
TELEPHONE (615) 322-7311

John F. Kennedy Center for Research on Education and Human Development
Box 151, Peabody College • Direct phone 322-8423

Demonstration and Research Center for Early Education

July 24, 1980
Family, Infant and Toddler Project

Hendersonville, Tennessee

Dear Mr. and Mrs. Hall:

You and your son Chris have been referred to our Family, Infant and Toddler Project by Rita Cunningham of Clover Bottom Community Services. I am enclosing a brochure which gives a brief overview of our Project.

For your further information, we will begin operating a family oriented educational clinic for children who are handicapped in Gallatin, Tennessee on August 1, 1980. We will conduct this clinic every Friday from 9:00 AM - 12:00 AM in the Gallatin First United Methodist Church (across from City Hall). We send out two teachers who will work with five children and families during the three hour clinic. During the first two hours of the clinic the teachers work individually with you and Chris, teaching you how to be Chris' teacher, and with the other children and parents. During the third hour of the clinic, all of the parents go to another room with one of the teachers, and the children remain with the other teahcer. During this third hour you will be participating in a parent group, and will receive information about child development, resources, and have opportunities to learn from and share with other parents some of the problems that arise and how different parents have solved them.

While you are in the clinic, professionals from Sumner county will be in a training seminar learning about working with handicapped children and providing educational programming. During the third hour, when you are in the parent group, the professionals will, under the supervision of the FIT training coordinator and one of the teachers, work with the children.

Prior to working with a family, we like to make a home visit screening to determine eligibility for our project and to explain more about our project. Following the home visit screening, if a child is eligible and a family wants to participate, we conduct a comprehensive evaluation at the Child Study Center on the Peabody College campus. This evaluation includes a parent interview, and psychological and educational evaluations. Through this evaluation, we can learn how Chris learns, Chris' strength's and weaknesses in learning, and your concerns and interests. This enables us to develop a program specifically suited to your and Chris' needs. This evaluation reflects our

Appendix B (continued)

philosophy that the parent is the child's primary teacher, and that an educational program for a child is best when it fits with family needs and life.

Vaughan Stagg is our staff person who arranges for home visits and evaluations. If you are interested in participating in our project or have any questions, please call Vaughan Stagg or me at 327-8236.

Sincerely,

Judith A. Davis
Project Coordinator

JAD/cal

Enclosures

Appendix C

Sample Application to FIT Project

and

Permission Forms

Appendix C

Permission for Project to Conduct Evaluation

GEORGE PEABODY COLLEGE FOR TEACHERS
J.F. Kennedy Center for Research
Family, Infant and Toddler Project
Box 151
Nashville, Tennessee 37203

Dear Dr. Gabel:

I would like to have my child evaluated for enrolling in the Family, Infant and Toddler (FIT) Project. I understand the evaluation, completed at the Peabody Child Study Center, may include an educational and psychological evaluation of my child and an interview with me about my child and our family. If my child participates in the FIT Project, this information may be used to plan an individual program for him/her.

In understand that the Project aims to find better ways to help young children learn by showing their families and other professionals working with them how to teach them. The information gathered from me and my child may be used to evaluate how well the Project is working. The results may be reported, without identifying me or my child, to other professionals interested in learning about the FIT Project. Also, visitors interested in the Project may observe your staff working with me and my child. Since Peabody College trains future professionals, I will allow graduate students in professional training programs to see the staff working with us during the evaluation and in the program. I give permission for tape recordings (audio and/or video to be made of me and my child for professionald audiences interested in the Project and for the staff to use in evaluating the program.

I know that I can withdraw this permission at any time without any penalties. I have noted that I can contact Dr. Harris Gabel at the address above or at 327-8236 if I have any questions about this Project.

Child's Name:_____

Parent or Guardian:_____

Witness:_____

Date:_____

Appendix C (continued)

EVALUATION APPLICATION*
Child Study Center

Date_____

Child's full name_____
Last First Middle

Name by which child is usually called_____

Date of Birth_____ Age_____

Sex_____ Race_____ Place of Birth_____

Home Address_____ Phone_____

Father's Name_____ Age_____ Highest grade completed___

Work Address_____ Phone_____

Occupation_____ Annual Income_____

Mother's Name_____ Age_____ Highest grade completed___

Work Address_____ Phone_____

Occupation_____ Annual Income_____

Legan Guardian: Parent_____: Mother_____ Father_____ Other_____

If "other," please complete: Name_____

Home Address_____ Phone_____

Work Address_____ Phone_____

Occupation_____ Annual Income_____

Siblings: List in birth order including applicant:

Name	Age	Pertinent Information (grade, occupation, health)

Other persons living in the home (grandparents, relatives, etc.)

Name	Age	Relationship to child

* Reprinted courtesy of Dr. Rebeccal F. DuBose Fewell who developed this instrument for use by the Multi-Handicapped Evaluation Team Child Study Center, Peabody College, Nashville, Tennessee 37203.

Appendix C (continued)

Medical History

PREGNANCY AND BIRTH

Mother's age_____ Father's age_____ at child's birth
This birth was the mother's_____pregnancy. Was this a planned pregnancy?_____ Describe the family's feelings (unhappy, angry, excited, etc.) toward the pregnancy_____

_____

Parent application for evaluation

Did the mother experience any miscarriages prior to, or after this birth?_____ If so, describe and state the suspected cause_____

_____

Please describe the pregnancy. Did the mother have any illnesses during the pregnancy or have x-ray treatments? Were there any accidents during pregnancy? Did the mother smoke during pregnancy?_____

_____

_____

Was this a full term pregnancy?_____ Weight of child at birth_____
Length of child's stay in hospital_____
Name and address of hospital and doctor:
Name_____ Address_____
Name_____ Address_____
If there were any complication at birth, please describe:

_____

_____

_____

VISUAL PROBLEMS (If your child has a known visual problem, fill out, otherwise omit)

When and how was the visual problem first noticed?_____

_____

_____

When did you take your child to have his eyes checked, and who referred you?_____
Describe what happened when your child's eyes were tested. _____

_____

What explanation was given as to the cause of your child's visual problem, and by whom?_____

_____

Appendix C (continued)

Have there been previous visual problems in family members? If so, describe and identify person involved._____

_____

_____

Describe the current status of your child's vision as told to you by his doctor._____

_____

_____

What have you been told about his vision in the future?_____

_____

How does your child use his vision in the home?_____

_____

_____

HEARING PROBLEMS (If your child has a known hearing problem please fill out, otherwise, omit.)

When and how was the hearing problem first noticed?_____

_____

_____

Where did you take your child to have his hearing checked, and who referred you?_____

_____

Describe what happened when your child's hearing was tested._____

_____

_____

What explanation was given as to the suspected cause of your child's hearing problem?_____

_____

_____

Have there been previous hearing problems in family members? If so, describe the problem and identify person involved._____

_____

_____

Describe the current status of your child's hearing._____

_____

If he wears an aid, state the kind and how long he has worn it._____

_____

What have you been told about his hearing in the future?_____

_____

_____

Appendix C (continued)

How does your child use his hearing in the home?_____

_____

SPEECH AND LANGUAGE PROBLEMS (If your child has a known speech and/or language problem please fill out, otherwise, omit)

When and how was your child's problem first noted?_____

_____

Where did you take your child to have his speech checked and who referred you?_____

_____

Describe what happened when your child's speech was checked._____

_____

_____

What explanation was given as to the cause of the problem?_____

_____

_____

Have there been previous speech and/or language problems in family members? If so, please describe the problem and identify the family member._____

_____

_____

Describe the current status of your child's speech and language._____

_____

If he receives therapy, state when it began and how long he has received it._____

_____

What have you been told about his speech and language in the future?____

_____

_____

How does your child use his speech and language in the home? How does your child communicate his needs?_____

_____

_____

PHYSICAL PROBLEMS (If your child has a known physical problem, please fill out, otherwise, omit.)

When and how was your child's physical problem first noticed?_____

_____

_____

Appendix C (continued)

Where did you take your child to have his physical problem checked, and who referred you?_____

_____

Describe what happened when your child's physical problem was checked

_____

_____

What explanation was given as to the suspected cause of your child's physical problem?_____

_____

_____

Has your child had any type of surgery for his physical problem? Describe the surgery, and identify where and who performed the surgery.

_____

_____

_____

Have there been any previous physical problems in family members? If so, please describe the problem and identify the person involved._____

_____

_____

Describe the current status of your child's physical problem._____

_____

_____

What have you been told about his physical development in the future?

_____

_____

How do his physical problems affect his daily living skills and his interaction in the home?_____

_____

_____

GENERAL HEALTH INFORMATION

During early childhood, did your child have any major illnesses? Describe._____

_____

_____

Has your child had very high fevers? Describe._____

_____

_____

Appendix C (continued)

Has your child had any convulsions, seizures, blackouts, etc.? Describe.

_____

_____

_____

Does your child have any allergies, coughing spells, breathing difficulties, pain in chest, etc.?_____

_____

_____

Has your child ever had any serious accidents? Describe._____

_____

_____

Has your child ever been hospitalized for any reason? If yes, describe and state the hospital and doctor._____

_____

_____

Please use the space below to describe any other medical or health data which might be helpful in understanding the child's problem._____

_____

_____

_____

PSYCHO-EDUCATIONAL INFORMATION

List any day care centers, developmental centers, and preschool and school programs which your child has attended.

Name	City	Level, grade, section
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been given a psychological or educational evaluation? If yes, describe the results as you understand them and who performed the evaluation._____

_____

_____

Are you presently following a home educational program? If yes, please describe._____

_____

Appendix C (continued)

Please describe what your child does best._____

_____

_____

What is your child's favorite activity or toy?_____

_____

_____

Describe your child's average day and with whom he spends most of his time._____

_____

_____

How does your family spend its weekends? Does your child participate with you, and how?_____

_____

_____

What kind of educational program do you feel would best meet your child's immediate needs?_____

_____

_____

What insurance or funding sources do you feel might support the evaluation of your child?_____

_____

_____

List below the names and addresses of physicians, clinics, and agencies familiar with your child and who can furnish information to us about their findings._____

_____

_____

Please list your greatest problem areas with your child._____

_____

_____

What specific questions would you like for this evaluation to answer?____

_____

_____

What are your goals for the evaluation?_____

_____

_____

Appendix C (continued)

I. Sensory Information

A. Does your child

___yes___no seem to have a vision problem?
___yes___no frequently rub his eyes?
___yes___no blink excessively?
___yes___no ever have red or watery eyes?
___yes___no turn his head to one side when looking at something?
___yes___no appear to see better out of one eye, which?_____
___yes___no wear glasses; if "no", disregard the following 3 questions
___yes___no depend upon his glasses?
___yes___no resist wearing them?
___yes___no care for glasses/lens independently?
___yes___no seem particularly interested in looking at light?
___yes___no spin or twirl bright shiny objects in front of eyes?
___yes___no look at what he is doing?

B. Does your child

___yes___no seem to have a hearing problem?
___yes___no frequently hit, hold, or pull his ears?
___yes___no ears produce a sticky fluid?
___yes___no turn his head to one side when listening?
___yes___no appear to hear better out of one ear, which?_____
___yes___no place his ear(s) on the objects producing noise/sound?
___yes___no cease activity when you talk to him?
___yes___no come when you call his name?
___yes___no respond in any way to doorbell, telephone?
___yes___no listen to TV or music?
___yes___no wear a hearing aid; if "no", disregard the next 3 questions
___yes___no depend upon aid?
___yes___no resist wearing it?
___yes___no care for aid independently?

II. Physical Information

Does your child

___yes___no seem to have any physical problems?
___yes___no move about independently?
which best describes the way your child get from one place to another
crawls on stomach___
scoots on back___
scoots on seat___
crawls on hands and knees___
walks___

Appendix C (continued)

uses: wheelchair___, crutches___, walker___, braces___, cane___

___yes___no have any artificial limbs, please describe below
___yes___no independently apply and remove artificial limbs or other equipment?
___yes___no reach and grasp?
hold up head___, turn over___, sit___, stand___
___yes___no have control over legs?
___yes___no have control over arms and hands?
___yes___no currently participate in a prescribed physical exercise program?

III. Speech and Language

Does your child

___yes___no look at your when you talk to him?
___yes___no establish eye contact
___yes___no communicate with you verbally?
___yes___no babble back when you talk to him?
which best describes your child's verbal communication
simple sounds___single words___combines two words___
two word sentences___three word sentences___
___yes___no sentences of four or more words
have a vocabulary of 10 or less___, 10-50___, 50-100___, 100-500___, 500-1000___words?
___yes___no communicate with you nonverbally?
___yes___no smile in recognition of you?
___yes___no point to what he wants?
___yes___no take you or put your hand on what he wants?
___yes___no have any type of speech impairment, please describe below
___yes___no cleft lip
___yes___no cleft palate
___yes___no have dental problems?
___yes___no involved in any type of therapy program?

IV. Self-help Skills

Does your child

___yes___no totally depend on you for all his self-care needs?
___yes___no toilet himself independently?
___yes___no have control over his bladder?
___yes___no have control over his bowels?
___yes___no require special toileting equipment, please describe below
___yes___no have urinary diversion appliances
___yes___no feed himself
___yes___no use special equipment during feeding?

Appendix C (continued)

take nourishment in the form of:
bottles only___
baby food___
blended table foods___
finger foods___
regular foods___

___yes___no have difficulties swallowing?
___yes___no have difficulties chewing?
___yes___no drink from a cup independently?
___yes___no drink from a cup held by you?
___yes___no brush his teeth independently?
___yes___no help dress himself?
___yes___no need some assistance with dressing?
___yes___no dress independently?
___yes___no bathe with assistance?
___yes___no bathe independently?

V. Social Emotional Information

Does your child

___yes___no enjoy contact with other people?
___yes___no enjoy playing with peers, siblings, or other children?
___yes___no spend the majority of the day with one specific person, who?_____
___yes___no ever play outside?
___yes___no seem to enjoy playing alone, away from others?
___yes___no initiate interaction with other people?
___yes___no seem to be excessively active?
___yes___no seem to be excessively passive?
___yes___no engage in self-stimulatory activities?
___yes___no physically abuse himself in any way?
___yes___no present other severe emotional or behavioral problems (please describe)_____

_____

_____

Appendix C (continued)

Photograph Consent

The Family, Infant, and Toddler Project (FIT)

Dear Parent or Guardian:

We will be taking pictures and slides of some of our children as they work to achieve various developmental goals. The pictures and slides will be shown only to groups interested in all areas of Special Education. Please complete the form below if you will allow us to photograph your child.

Sincerely,

_____
Teacher - Coordinator

_____
Phone Date

_____
Date

Please check and return

( ) I would like to have my child's picture made for use in the FIT Project presentation.

( ) I prefer that my child not have his picture made.

_____ _____
Name of Child Signature of Parent or Guardian

_____ _____
Birthdate of Child Address

_____
Phone

George Peabody College for Teachers
VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37203 TELEPHONE (615) 322-7311

John F. Kennedy Center for Research on Education and Human Development
Box 151, Peabody College • Direct phone 322-8425

Demonstration and Research Center for Early Education

Dear Parents:

As you know, one of the activities of the FIT Project is training professionals in related fields to help them learn to be teachers to young handicapped children. The professionals involved in the training program in include . The FIT Project is providing training so that more skilled professionals will be available in your area to educate young handicapped children.

As part of their training, we would like the professionals to work with us and the children while parents are in parent group during the last hour of the FIT clinic. And, to help them understand the children and how we teach them, we are asking your permission to allow the professionals in our training program to read the Peabody Child Study Center evaluation reports and FIT educational programming information in your child's files that trainers bring to the clinic. Of course, we expect the professionals to keep all information confidential.

We think it will be helpful in the future for children in our Project to have more local professionals who know how to teach them. At the same time, you may certainly decide not to have the local professionals work with your child or see his or her files and your own participation in the FIT Project will not be affected at all. Services will be offered to you and your child whatever you decide.

If you agree to allow the local professionals named above to work with us and your child in the FIT clinic and to see your child's files, please sign below.

Sincerely,

Harris Gabel, Ph.D.
Associate Professor of Psychology
Director, FIT Project

Judith A. Davis
Project Coordinator

Child's Name: _____

Parent or Guardian: _____

Witness: _____

Date: _____

Appendix C (continued)
Permission for Local Professional Trainees to Teach Parents' Children

Appendix D

Sample Screening Report

Appendix D

Family, Infant and Toddler Project
George Peabody College for Teachers of Vanderbilt University
Nashville, Tennessee 37203

SCREENING REPORT

Child's Name: Danielle Richards
Date of Birth: 4/21/79
Age: 11 months
Parent's Name: Jackie Richards
Address: Apt. C, 102 3rd Street
Polk, Tennessee

Date of Screening: 3/24/80
Screener: Judith Davis

BACKGROUND INFORMATION: Danielle was referred to the FIT Project in January, 1980 by Ann White, Child Health and Development worker with Polk Public Health. The reason for referral was spina bifida with accompanying complication.

Danielle has been hospitalized twice in addition to her month long hospitalization following her birth. Entry into the FIT Project, and this screening was delayed by her most recent surgery to implant tubes between her bladder and kidneys. Her other hospitalization was to open her skull because the soft spot on her head had closed too quickly. Danielle's development is being followed by Dr. Hickman, White, and Owen at Vanderbilt University Hospital.

DENVER SUMMARY AND BEHAVIORAL OBSERVATIONS: Danielle was sitting contentedly in her father's lap when I arrived for the home visit screening. She remained in his lap while I introduced myself and described the FIT Project to her parents.

Danielle cannot lay on her back and must be held carefully due to the delicate skin covering the closure of her meningomyelocele. This inability to have extended contact with anything on her back, in addition to dislocated hips, has inhibited Danielle's gross motor and fine motor development. She is unable to roll over or sit up independently, and has difficulty holding her head in a steady upright position for any length of time. Danielle appeared to have weak muscle tone in her upper trunk and neck, but this may be due to having just completed a seven week hospitalization for surgery. The spina bifida and dislocated hips prohibit Danielle from bearing any weight on her feet and legs.

In the area of fine motor-adaptive development on the Denver, Danielle passed the items of taking cubes, attaining a raisin by a raking motion, passing a cube from hand to hand, reaching for toys. She did not bang two cubes together or demonstrate a thumb-finger grasp. Due to gross motor limitations and difficulties in positioning, no clear behaviors were evident in discerning whether Danielle did or did not look for the yarn.

Appendix D (continued)

In the DDST area of personal-social behavior, Danielle worked for the toys out of reach, resisted toys being pulled from her, played peek-a-boo, indicated wants and reportedly feeds herself teething biscuits. Danielle demonstrated no shyness with me. While Danielle does not play pat-a-cake by herself, she seemed to thoroughly enjoy my guiding her through the movement of the game, and indicated by fussing or reaching for my hand that she wanted to continue playing pat-a-cake with me.

Danielle is a quiet child. She did not vocalize frequently or loudly during the home visit. Occasionally she would become fussy if her back was in contact with another surface for too long. Mrs. Richards reported that Danielle does babble and imitates some speech sounds. On one occasion when Mrs. Richards left the room, Danielle visually followed her mother and called out "mama" when she could no longer see her mother.

During the screening, Danielle particularly enjoyed crumbling and waving two pages that were torn out of a magazine. Danielle was responsive to me in her quiet way and demonstrated interest during every activity of the screening situation. Danielle also demonstrated great interest in hair: she held and ran her fingers through my hair in apparent fascination without ever pulling my hair. She also held and played with her mother's hair in the same fashion. While being held by her mother, Danielle tried to play with her mother's mouth by putting her fingers in her mouth. She also gave her mother "sugar" on a number of occasions.

Danielle demonstrated delays in three of the focus areas measured in the Denver Developmental Screening Test.

FAMILY SITUATION: Danielle is the youngest of two children and lives at home with her parents and five-year-old sister, Sherry. Mrs. Richards works at the Gino Bakery and Mr. Richards is a auto mechanic. Danielle spends her days with a babysitter.

Mr. Richards did not remain for the entire home visit. He expressed concern about the high cost of medical care for Danielle and their ineligibility for any financial assistance due to their income. I suggested that we can help them in finding possible resources. He mentioned the need for equipment such as a special chair which will cost $500-$700. I told him how we sometimes find out about one-time-only monies that become available for special equipment.

Mrs. Richards commented that in addition to the high costs of special materials and equipment, they also must contend with no help in finding resources, and the fear that other people have about touching or holding Danielle. She told me that after Danielle's last hospitalization, her babysitter seemed hesitant to take care of her. They resolved the situation, but the babysitter's reluctance was related to her fear of handling Danielle.

Appendix E

Sample Evaluation Report

Appendix E

Family, Infant, and Toddler Project
George Peabody College for Teachers of Vanderbilt University
Nashville, Tennessee 37203

PSYCHOLOGICAL EVALUATION

Client: Phillip Thomas
Date of Birth: 8/28/79
Age: 7 months, 22 days
Date of Evaluation: 4/20/80
Examiner: Carl Dunst
Parent: Karen Thomas
Address: 110 Lewis Drive
Bakersville, Tennessee

REASON FOR REFERRAL: Phillip was referred to the Family, Infant, and Toddler (FIT) Project by Ann White, an Owen County, Tennessee Public Health nurse. The present evaluation was conducted to determine whether Phillip met the criteria for enrollment in the FIT Program. The purposes of the evaluation were to determine Phillip's current developmental level of functioning and make recommendations based on the outcome of the evaluation.

BACKGROUND INFORMATION: It was reported to the FIT Project staff that Phillip was diagnosed as having Down's syndrome by Dr. James, the family physician. A subsequent genetics study conducted by Dr. McRae at the Vanderbilt University Hospital confirmed this diagnosis. The only previous developmental evaluation reported was a Denver Developmental Screening Assessment conducted by Geraldine Knight of the Ingram Clinic in Bakersville Tennessee, just two weeks ago. Phillip does not presently receive any psychoeducational intervention, although it was reported that the mother was interested in obtaining information concerning ways to stimulate Phillip's development.

TEST ADMINISTERED: The mental scale of the Bayley Scales of Infant Development was administered for the present evaluation.

BEHAVIROAL OBSERVATION: Most of the evaluation was conducted with Phillip in an infant seat or lying supine on the floor. Phillip apparently had a cold (he sounded stuffy and had a runny nose), and he seemed uncomfortable at times. Therefore, optimal performance may not have been obtained.

Phillip showed no fearfulness of the testing situation or the strange setting, although direct approaches by the examiner often elicited crying or fussing. Excessive demands by the examiner to have Phillip perform certain tasks also elicited negative reactions from him. Phillip, not unexpectedly, was much more responsive to the mother's approaches. When he was left alone, Phillip seemed content and happy and occasionally cooed. Generally, Phillip seemed "more to himself" and exhibited minimal interests in other persons and the external environment (including the test materials).

Appendix E (continued)

On several occasions, Phillip did manifest persistent goal-directed behaviors, particularly in response to attempts to obtain objects he wanted. For example, in reaching for the red ring, he "worked" up to a minute in order to secure it. Phillip's attention span during the test situation varied depending on particular tasks. For example, he maintained long and continued interest in his mirror image, whereas he showed minimal interest in manipulating objects. However, Phillip's endurance for the test situation was excellent, particularly for a child his age. He "held-up" extremely well not only throughout the test, but during the entire assessment day as well.

In terms of his behavioral capabilities, Phillip spent a considerable amount of time engaging in "hand watching". He showed some interest in visually following and exploring objects, and manipulation of objects placed in his hands. Phillip showed minimal interest in attending to and locating the source of sounds, although both of these behaviors were observed. He vocalized minimally, although the sounds he did produce were of good quality. Overall, Phillip responded more to stimulus inputs provided by the examiner rather than actively attempting to produce and control input information.

RESULTS: The results obtained showed Phillip attained a mental age equivalent in the four and one-half to five and one-half month range. His range of abilities varied from a two month (visually recognizes his mother) to a six-month level (attends to scribbling). These results indicated that Phillip is currently manifesting a two to four month developmental delay. The tests passed and failed between the first and last items administered were as follows:

Passed	Failed
2 Months	
Visually recognizes mother	Social smile: E smiles, quiet
Vocalizes to E's smile and talk	Reacts to disappearance of face
Searches with eyes for sound	
Eyes follow pencil	
Vocalizes two different sounds	
Regards cube	
Manipulates red ring	
Glances from one object to another	
Anticipatory adjustment to lifting	
Simple play with rattle	
3 Months	
Reaches for dangling ring	Aware of strange situation
Follows ball visually across table	
Fingers hand in play	
Head follows dangling ring	

Appendix E (continued)

Passed	Failed
2 Months (continued)	
Head follows vanishing spoon	
Carries ring to mouth	
Inspects own hands	
Closes on dangling ring	
Turns head to sound of bell	
Turns head to sound of rattle	
4 Months	
Reaches for cube	Manipulates table edge actively
Eye-hand coordination in reaching	Regards pellet
Mirror image approach	Picks up cube
Vocalizes attitude (displeasure)	Discriminates strangers
Retains two cubes	
Exploitive paper play	
Recovers rattle	
5 Months	
Reaches persistently	Lifts inverted cup
Likes frolic play	Reaches for second cube
Turns head after fallen spoon	Smiles at mirror image
Bangs in play	Exploitive string play
Sustained inspection of ring	Transfers object hand-to-hand
Attends to scribbling	Picks up cube directly
	Pulls string - secures ring
	Interest in sound production
	Lifts cup with handle
6 Months	
	All items failed

While it was the case that Phillip passed many of the test items which assess "outerdirected manipulative" behaviors, it was generally found that he showed minimal interest in response-contingent situations and events. In fact, the only test item on which he showed an ability to understand that his behavior had an effect on producing reinforcing consequences was "exploitive paper play." Most often, Phillip remained a passive respondent to stimulus inputs rather than being an active participant in initiating interactions with persons and objects. This is consistent with the observations made earlier that Phillip seemed "more to himself" rather than interested in the external environment. However, in terms of his overall developmental performance, it was clear that Phillip is in a transitional phase between "auto-centric" interests (fingers hands in play, bangs in play). This is a typical sequence of

Appendix E (continued)

development; and although Phillip is manifesting a developmental delay, he is showing a usual pattern of development.

RECOMMENDATIONS:

1. Because Phillip is manifesting a delay in development and as a result he has unique developmental needs which can be attended to through the services provided by the Family, Infant, and Toddler Project, it is recommended that Phillip be enrolled in the FIT Project in order to receive both the child and family services offered.

2. The initial focus of intervention for Phillip should be on fostering response-contingent behaviors. Situations and activities need to be developed which facilitate the ability to have Phillip understand that his own actions can have an effect on producing interesting events and other reinforcing consequences in his environment (e.g., smiling to have someone tickle his tummy). It would be best to attempt to foster a wide range of such response-contingent behaviors, including: shaking rattles, batting at mobiles, kicking at mobiles, "talking" to adults to have them talk back, patting squeeze toys, "jumping" in a jolly-jump-up, and similar type behaviors.

3. Inasmuch as Phillip showed minimal interest in visually exploring his environment, intervention activities should be developed to foster visual exploratory behavior. Thus, he should be provided the opportunity to look at interesting displays, focus on sources of light, be stimulated visually with illuminous materials, etc. Since visual exploratory behaviors are best elicited when in a sitting or upright position as effort should be made <u>not</u> to have Phillip spend most of his waking hours lying supine or prone on the floor or other surfaces.

Carl J. Dunst, M.A.
Psychological Assistant

Supervised by:

Harris Gabel, Ph.D.
Clinical Psychologist

Appendix E (continued)

Family, Infant, and Toddler Project
George Peabody College for Teachers of Vanderbilt University
Nashville, Tennessee 37203

EDUCATIONAL EVALUATION

Client: Phillip Thomas
Date of Birth: 8/28/78
Age: 7 months, 22 days
Date of Evaluation: 4/20/79
Examiner: Beth Langley
Parent: Karen Thomas
Address: 110 Lewis Drive
Bakersville, Tennessee

Testing Results of the Griffiths Mental Development Scale:

Locomotor:	5 months
Personal-Social:	6 months
Hearing and Speech:	4 1/2 months
Eye and Hand:	5 1/2 months
Performance:	4 1/2 months

Overall developmental level: 5 months

OBSERVATIONS OF COGNITIVE-ADAPTIVE: Phillip was a very cooperative child with whom to work. He was very socially-oriented and responded positively to adult attention. He smiled, vocalized, and waved his arms when the examiner tickled him, and he established eye contact with the examiner when she called his name. When presented with a mirror, he leaned forward slightly, smiled at his image and licked the surface. He held a spoon that was placed in his hand and drank juice from a cup that was tilted up to his mouth. He cried only when he accidentally fell backwards, and he reacted passively when the examiner made arm motions to indicate that Phillip was going to be lifted.

With most objects Phillip utilized the same scheme of shaking the object while bringing it toward his face. In this way he manipulated a rattle, a wooden ring and a spoon. Although he did not spontaneously reach for or pick up a toy, he accepted up to two objects if placed against his hand. While holding a doll he slightly resisted the examiner's attempt to take it away from him. When a white cloth was placed over his face, he put his hand up to his face and made small swiping movements at the cloth, without actually grasping it. After approximately six attempts he was successful in removing the cloth from his face. Searching behavior was emerging and was inconsistently evident when the examiner dropped a toy that Phillip had been watching. At times his eyes followed the dropped objects, and he leaned over slightly to see it on the floor.

Appendix E (continued)

Throughtout the evaluation Phillip's behavior reflected two important deficits that influenced his performance in all areas: 1) Passivity, and 2) Lack of interest in objects. It was clear that he enjoyed adult attention; however, he did not actively seek it or anticipate it. Objects were placed in his hands rather than his reaching for them. It is important that he develop the motivation to act on his environment so that he will acquire important cognitive skills such as object concept, spatial awareness, imitation, cause-effect relationships, etc. Physical play-like stimulation should help him become more aware of other agents around him. Materials used with Phillip should be manipulative and visually oriented.

OBSERVATIONS OF MOTOR: Phillip's muscle tone was within the normal limits for a child of seven months of age. Hypotonicity (weakness or floppiness) was not evident as it often is in children with Down's syndrome. All limbs were passively moved through their full range of motion. Body alignment was symmetrical.

Mastery over head control had been achieved in supine, prone, and sitting postures, although an inconsistent but intermittent head lag was noted on pulling Phillip to a sitting position. He adjusted his posture after the initial pull to maintain his head in line with his trunk but he was not observed to lead the sitting motion with his head. Although he demonstrated emerging coordination patterns for sitting, Phillip's legs rose bilaterally from the surface with initial pulling to sit reactions. When lightly supported at his hips in a straight-legged posture, Phillip maintained a fairly straight back with minimal curve evident in his spine.

His retention of the Moro reflex (head moving back, arms lifting and extending) prevented any equilibrium reactions or protective responses that would enable him to recover lost balance in order to sit steadily.

Strength and coordination were most advanced when in a prone position. Phillip raised his head 45° from the surface and supported himself on his forearms. Although he was observed to roll from his side to his back, his mother reported that he often rolled from his stomach to his back.

Upper extremities moved primarily together but independent coordination was emerging. While Phillip had not yet developed a voluntary grasp or release, his hands remained open and he grasped on contact if objects were small and pliable. He indicated a preference for his right hand in the majority of activities. Phillip was occasionally observed to hold his left arm flexed (bent) and the elbow slightly abducted (held up and away from his body) when performing tasks in a sitting position. Midline skills (working with both hands in the center of his body) were often inhibited because of this posture. Phillip consistently brought his hand to his mouth and objects before his eyes to examine them. He momentarily held two objects simultaneously.

Appendix E (continued)

Phillip exhibited more development of his larger muscles than his fine muscles. He primarily lacked strength and control due to the absence of development of some basic postural reactions. His lack of more advanced abilities to use his small muscles appeared to be inhibited by his lack of visual attention to his hands and lack of tactual stimulation. Although there is a range of time when Down's syndrome children perform certain motor activities, especially rolling over and sitting alone, there also is an average time that these milestones are accomplished by the majority of Down's children. The average age at which Down's children roll over is eight months, although, this skill can be acquired from four to twenty-two months. Sitting independently for many Down's children occurs at ten months, but ranges from six to twenty-eight months.

OBSERVATIONS FOR HEARING AND SPEECH: Because there is frequently a hearing loss associated with Down's syndrome, Phillip was screened with calibrated noise-makers ranging from 55 to 105 dB and of both high and low frequencies. Phillip's most characteristic responses to sound were a cessation of breathing or ongoing activity, eye widening, and an occasional shifting of his eyes in the general direction of the noise-maker if presented laterally. He did not exhibit a startle response to any sound. Phillip turned his head to localize a bell when rung and turned to look at the examiner when she called him. His responses to the various noise-makers were as follows:

Toy:	Estimated dB Level	Response:
1. Musical radio	55 dB	Eyes shifted
2. Ring stack with bell	60 dB	No response
3. Cow sound	67 dB	Eyes widened
4. Metal spoon and cup	70 dB	No response
5. Cow bell	75 dB	Cessation breathing
6. Red-headed rattle	70 dB	No response
7. Dragon squeak toy	74 dB	Cessation breathing
8. Mouse squeak toy	79 dB	Cessation of activity
9. Medium bell	80 dB	Cessation of activity; Eyes shift
10. Wooden clacker	85 dB	No response
11. Large bell	90 dB	Eyes shift
12. Metal cricket	105 dB Impulse level	No response

Expressively, Phillip babbled six different syllables during the evaluation and uttered two syllable combinations. His vocalizations included babu, didu, dada, uh, m, and gutteral phonemes. He vocalized when he was content and when actively engaged in looking and touching tasks. He conveyed dissatisfaction rarely except when in pain.

Appendix E (continued)

Language skills were significantly affected by his infantile and inconsistent response to sound. While it is possible that Phillip is using his hearing on a level similar to that of his cognitive development, it is also possible that he has a hearing loss and this should be checked as soon as possible. His variety of vocalizations, however, make the possibility of a hearing loss more suspicious.

ACTIVITY SUGGESTIONS:

1. Phillip needs to become more aware of his environment so that curiosity and initiative can develop. Some ideas for sensory stimulation are:
    a) Place Phillip in his crib on surfaces of varying textures - corduroy, satin, vinyl, textured knit, etc., getting one-half to three-fourths yard pieces of interesting materials at a fabric store. These can be sewn loosely onto the crib sheets.
    b) Play frequent tickling and bouncing games with Phillip. Splash him in his bath. Move his arms and legs vigorously in play.
    c) Before feeding Phillip present the bottle, cup, or spoon from various directions before he is allowed to start sucking or eating.
    d) Attach colorful objects that Phillip can bat at above, as well as on, the sides of his crib.

2. Give Phillip different (but simple) toys that he can act on. For example:
    a) Sunflower - mirror rattle
    b) Soft squeak toy
    c) Drum

    Physically guide him to act on each toy appropriately - shaking, squeezing, banging. Fade prompts when possible.

3. Encourage Phillip to hold two objects at a time.

4. For something that Phillip really wants (such as food, etc.), hold it so that he must reach for it. Prompt him if necessary to help him understand that he is able to obtain it.

5. To encourage his rolling from his tummy to his back consistently, gently lift up on his chin, turn his head to the right, and lift up on his right shoulder.

Appendix E (continued)

6. To bring his shoulders forward so that he can see his hands and achieve upper bilateral symmetry, place Phillip on his tummy over a wedge.

M. Beth Langley

M. Beth Langley, M.A.
Diagnostic Evaluator

Appendix E (continued)

ACTIVITIES

Rolling:

I. Goal: The child is able to roll from back to either side and back again.

Actions:

1. Carry the child around to stimulate a response to changes in position. Stop, start, change directions, turn around, back up, lean over, straighten up, sit down, stand up again. At the same time, change the child's position in your arms from time to time--erect over your shoulder, lying down in your arms, head one way, then head the other way. Carry the child on your back for awhile, and then on your chest.

2. Start with child lying on his back. Roll the child back and forth, from side to side, talking playfully all the while.

II. Goal: The child is able to roll over, from back to belly in either direction.

Actions:

1. With child lying on the back, roll the child back and forth toward one side. Each time roll the child further until gravity rolls the child over onto belly. Encourage the child to lift head and get arm out from under the body. Help only if necessary.

   Repeat the activity as often as the child tolerates it without resistance. Make a game of the activity. On alternate tries roll the child toward the other side.

2. Assisted rolling - Lay the child on his back. Turn child's head to the left and tilt chin up. Pull child's right hand across the body and up just beyond the left shoulder. Hold the child in this position until child makes some attempt to complete the roll; then assist only as needed.

   Reposition the child on his back again and reverse the procedure; roll the child over toward the right.

3. Place child on side. Show child an attractive toy. Place the toy just out of arm's reach and at about level with the top of child's head. Position it where it can still be seen. Encourage the child to reach for the toy with upper arm. As the child reaches, child will roll over. Let child play with

Appendix E (continued)

the toy briefly, then reposition. Make several tries to the left, then several to the right.

When child can do this easily, begin from a position midway between back and side-lying. Prop child with a pillow or with your hand, then proceed as before. When child can roll easily from this position, start from back-lying. Show child the toy. As child reaches for it move the toy so that child must roll over to reach it. Be sure to let child have the toy for a time after each successful roll.

4. Roll over the leg leading - With child lying on back, lift child's right leg with the knee bent and cross it over left. Press child's knee toward the mat until his right leg is raised. Hold in this position until the child rolls over. At first, turn child's head to the left, tipping face up, to emphasize the movement. Give only as much assistance as necessary.

   Reverse procedure to get child to roll over to the right. Be sure to give equal practice rolling in each direction.

5. With the child lying on back, present a toy just out of arms' reach. Move to one side and slightly above child's head, keeping it within the child's field of vision. Encourage child to roll over in order to get. Give child only as much assistance as needed to accomplish the task. Often child only needs enough assistance just to keep from rolling back. Be sure to work from both right and left sides. It may be necessary to substitute tactual and/or auditory stimuli for those who are unable to respond to the visual stimulus.

III. Goal: The child is able to roll from belly to back in either direction.

Actions:

1. Turning head and shoulders first - Place the child face down on the floor. Draw child's left hand across and under body at shoulder level. Turn child's head to the right and tip face up. Hold child in this position until child rights self by rolling over. Reverse the procedure to help child turn over from the left. Practice from both sides equally.

2. Pushing with arm and leg - Place the child face down on the floor. Turn child's head to the right. Place one hand under the right side of child's pelvis and lift sharply. Child's right hip and knee will bend. Once child has responded, continue to hold the right side of child's pelvis up. Also hold child's right foot against the floor. Encourage child to turn self by pushing with the right arm and leg to turn over.

Appendix E (continued)

Reverse this procedure to assist child to turn over from the left.

3. Active-assisted rolling - With the child lying face down, hold a sound toy above, behind and a little to the right of child's head and shoulders. Attract child's attention. Child should be able to see the toy by lifting and turning head. Encourage the child to turn over to reach for toy. Present the toy alternately on the right and the left. Assist child when needed, but only as much as needed to succeed by working hard at the task.

Sitting:

I. Goal: The child holds head erect when supported in the sitting position.

Actions:

1. Support the child in a sitting position by holding the shoulders. The child may be on your lap, on a table, or sitting on the edge of the table with his feet dangling.

   a) Holding the child by the shoulders, tilt the child backwards just far enough for the child to lose head balance. Then, slowly, bring the child upright. Encourage the child to pull head up to balance. If the child cannot, bring head forward allowing gravity to help.

   b) Tilt the child diagonally back and to one side, twisting the child slightly so the opposite shoulder moves farther back. When the child loses head balance, slowly bring the child back. Encourage the child to regain head control. Repeat to the opposite side.

2. General balance stimulation - Seat the child on your lap facing you. Support the child with your hands around the lower ribs. Bounce the child up and down and from side to side with your knees. Make a game of this activity using nursery rhymes or songs similar to the following:

   a) Ride a cock horse to Banbury Cross,
   To see a fine lady ride a white horse.
   Rings on her fingers and bells on her toes,
   She shall have music wherever she goes!

   b) This is the way the child ride,
   Tippety, tippety, tip!
   (Bounce with small bounces)

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This is the way the ladies ride,
Clippety, clippety, clip!
(Bounce with medium bounces)

This is the way the gentlemen ride,
CLOPPETY, CLOPPETY ,CLOP!
(Bigger and bigger bounces)

II. Goal: The child brings hands together at the midline and, at the same time, attempts a voluntary grasp.

Actions:

1. Place the child on side with hips and knees bent. Pull lower arm and shoulder forward. Press the upper shoulder forward so that both arms are in front of the child. Carry out the following activities first on one side and then the other.

2. Rub each palm briskly with your finger tips, opening the child's hand if necessary.

3. Place the child's hands together, pat them together, rub them together, curl one hand around the other. Talk to the child, sing, or say jingles to keep the child's attention and to prevent any resistance.

   Variation: Place a sticky substance like honey, molasses or taffy on the child's palms to intensify tactual reception and to draw the child's eyes toward hands.

4. Place squares of cloth of different textures--rough, smooth, soft--between the child's palms and rub his hands against them. Pull one between the child's index and middle finger and leave it there to see if the child will attempt to get rid of it.

   Variation: (a) Offer the child three wood blocks which have been covered on both sides with assorted textures. (b) Offer the child assorted small sponges.

5. Place a small ball, block or other bright colored toy between the child's hands. Move the child's hands around on the block. Encourage the child to hold the block with one or both hands.

6. Dangle a noise-making toy near the child's hands. Get the child's attention and encourage him to grasp the toy.

7. Place a brightly colored toy near the child's upper hand. Encourage the child to reach for and grasp the toy.

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8. Dangle a toy from a string at shoulder level. Sit behind Phillip and guide him from above his elbows to reach out and strike the toy. Be sure that he:

    a) reaches with each hand,
    b) crosses his midline, and
    c) strikes it as it dangles at either side.

Language Activities:

1. Continue to babble Phillip's own sounds to him and imitate when he "talks" to you.

2. Seat Phillip facing you on your lap. Say to him and let him feel your mouth as you say, "Mamama" and "Bababa". Take his hand to his mouth and continue to babble the same sounds.

3. As you bathe and dress Phillip, simply label his body parts as you touch each one. "Mama's got your leg. Feel the water on your leg?" "Let's pull the shirt over your head. Let's put the sock on your foot".

4. Sit behing him and activate his different toys at ear level. Do it as softly as possible so you do not scare him. Say, "Listen! Phillip! What do you hear?" "Find it." Guide his head to turn so that he can see the toy. Help him take it and then activate the toy again with your hands over his. Be sure to use different toys and to activate them beside his left and his right ear.

5. Play Pat-a-cake and Peek-a-boo games with him. Guide his hands to go through the clapping and peeking motions.

Appendix E (continued)

Family, Infant, and Toddler Project
George Peabody College for Teachers of Vanderbilt University
Nashville, Tennessee 37203

PARENT INTERVIEW

Client: Lisa Davis
Date of Birth: 1/15/78
Age: 9 months
Date of Evaluation: 10/15/78
Examiner: Pat Papero
Family Participants: Frank and Gwen Davis (parents)
Mrs. Helen Davis (grandmother)
Address: 151 Lynn Drive
Bakersville, TN

REASON FOR REFERRAL: Lisa was referred to the Child Study Center for a psycho-educational evaluation by the Family, Infant, and Toddler Project to determine her current level of functioning and educational needs and her eligibility for the Project services.

BACKGROUND INFORMATION AND DEVELOPMENTAL HISTORY: Lisa, a nine month old white, female infant, is the second-born Davis child. She was diagnosed "brain damaged" at eight months of age by Dr. Stagner of Vanderbilt Hospital after Dr. Adair (general practitioner in Bakersville, Tennessee) expressed concern about Lisa's development and referred the family to Dr. McCoy, a Nashville neurologist. The Vanderbilt physician placed Lisa on seizure medication and has changed and adjusted her medicaltion since then. Dr. Adair also referred the Davises to Dr. Peterson in Clarksville at three months for diagnosis and treatment of a dislocated hip. Lisa was in a body cast from three to seven months of age, then wore a hip brace day and night until a week ago, when bracing was restricted to nighttime.

The Davises report that they perceived no developmental problems until Lisa reached three months of age. Pregnancy appeared normal. Mrs. Davis delivered Lisa by Caesarean section without complications (the first child had also been delivered Caesarean). Mrs. Davis did have one miscarriage (at three months gestation) about one and one-half years before Lisa's birth. The Davises have recently wondered whether taking Flagil (which was prescribed and taken for an infection when Mrs. Davis was six-months pregnant with Lisa) might have harmed Lisa, they have not checked this concern yet with a physician.

Lisa was followed for pediatric care by Dr. Wallace (and partners Drs. Darden and Curley). At three months, after the public health nurse questioned them a second time about a possible hip problem, Mr. Davis consulted their personal physician, Dr. Adair, and were referred to Dr.

Appendix E (continued)

Peterson. The Davises expressed their dissatisfaction that their pediatrician did not identify Lisa'a hip or seizure problems.

For the time being the Davises plan to consult Dr. Adair for the whole family's medical needs. They also have a follow-up meeting scheduled with Dr. Stagner for January 5th. They report that Dr. Stagner discussed with them the possibility of their obtaining further pediatric testing at Vanderbilt University Hospital to attempt to ascertain any causal factors for Lisa's brain damage.

Mrs. Davis identifies the three-month age level as the point when she really began to note delays in Lisa's development. At that time, she could not yet hold her head. The parents report little evidence of progress until medication was introduced and the body cast removed about one month ago. Since then Lisa has been more alert and active when awake. Until the cast was removed, all family members felt reluctant to handle Lisa freely.

PRESENT FUNCTIONING: Mrs. Davis judges that Lisa is currently functioning at about the three month level. She can hold her head up when lying down. She is beginning to pull up by her arms while holding Mrs. Davis's fingers. Since starting the medication, she has shown more signs of pleasure; during the baths she coos, smiles, and stretches her body with pleasure; during feedings she smiles and shows bodily excitement. She does not take her hand to her mouth or reach for objects regularly. Lisa is awake for about two hours in the early morning, two hours around noon, and then from about 2:30 until 7 PM except for a thirty-minute nap.

PRESENT FAMILY SITUATION: Mr. Davis works full-time in Nashville with the National Guard and has also held an additional part-time job for the past two years. Mrs. Davis is at home full-time with Lisa and Tommy, five, who will enter kindergarten next year. Both Mr. and Mrs. Davis's families live in the Bakersville area. Frank is one of three boys and Gwen is one of six girls and six boys. Frank and Gwen state that they do not have much time away from the children but are content with this arrangement. When they need any help with the children, the grandparents and cousins appear glad to help out. Mr. Davis reports that Tommy takes quite a responsible attitude toward Lisa. Neither parent identifies any family needs at this time related to Lisa's care.

Mr. David does note that he found it easier to relate to Tommy as a baby than to Lisa. He attributes this to his lack of familiarity with raising girls and to past difficulties in handling Lisa in her cast. Mr. Davis believes it is important to focus on positive ways to help Lisa rather than to think negatively about the future. While Mr. Davis assumes his wife will be much more involved in work with Lisa than himself, he is willing to arrange to meet with the Family, Infant, and Toddler staff regularly and to become more involved. Mrs. Davis appears currently to be experiencing strong feelings of sadness. She is relieved, however, to have Lisa's problems identified and resources located. Neither parent

Appendix E (continued)

has had regular contacts with other families of handicapped children; there is a delayed adolescent child in the extended family.

Since the family has had only a month's time to adjust to Dr. Stagner's diagnosis, they are understandable still learning how to accept Lisa's developmental problems. The family appears responsive to opportunities to discuss their reactions with each other and with concerned professional staff. Mr. Davis' mother, Mrs. Paula Davis, appears interested and concerned for their emotional needs at this time. Both parents' attitudes appear realistic, hopeful, and very warm toward their children.

PRESENT AND FUTURE CONCERNS: Overall, the family's concerns center around two areas: Lisa'a past and present physical well-being, and her developmental needs. Mr. Davis asked for help in exploring whether Lisa's treatment by her pediatricians warrants any form of official complaint and, if so, how to proceed. Both parents would like to obtain the services of an allergist. They also want to know how much vision Lisa has. They are not sure at present whether they want to pursue further testing to determine possible factors contributing to Lisa's brain damage. The family would like educational help from the Project in order to work more effectively with Lisa. Their long-range concern at this time is whether Lisa will be able to care for herself in the future.

IMPRESSIONS AND RECOMMENDATIONS: Mr. and Mrs. Davis both appear very eager to work with the Family, Infant, and Toddler Project to aid Lisa's development. They were delighted at her responsiveness to testing. They appear to value their children and family life highly. Both parents and the grandmother wish to be directly involved in learning how to work with Lisa as parent teachers.

While Mr. and Mrs. Davis appear to have strong personal resources and family support, they might benefit from opportunities to explore their feelings and reactions to Lisa's handicaps. They have not yet had very long to adjust to the medical diagnosis, and each parent might benefit from further discussion of their individual responses. It is likely that particular issues touch each of them differently.

SPECIFIC RECOMMENDATIONS:

1. The Family, Infant, and Toddler Project should assist the parents in working with Dr. Adair to determine if a referral for the services of an allergist is necessary.

2. Both parents should participate in the educational programs of the FIT Project as fully as possible so that each can share responsibility for stimulating Lisa's development, gain a sense of expertise in caring for her, and better understand educational goals and methods which can benefit Lisa. While both parents could not be expected to give equal time, a sense of shared responsibility for stimulating Lisa's development should be encouraged. Mr. and Mrs. Davis should

Appendix E (continued)

also be encouraged to utilize the Project staff as resources with whom they can discuss their concerns.

3. The FIT Project should help Mr. Davis to locate organizations or reliable information sources which he can use to determine whether he wishes to take any action in regard to past pediatric treatment.

4. Other family members such as Mrs. Paula Davis should be invited to participate and learn about the educational program as well.

Supervised by:

Harris Gabel, Ph.D.
Clinical Psychologist

Patricia Papero, M.A.
Psychological Assistant

Appendix F

FIT Clinic

Equipment and Supplies

Appendix F

FIT Clinic Supplies

From Carr, A. (Ed.) The family, infant, and toddler (FIT) Guide Nashville: George Peabody College of Vanderbilt University, 1982.

Bibs
Wash cloths
Towels (for positioning children)
Baby blankets
Paper towels
Baby wipes
Disaposable diapers - (families usually brought their own)
Food for snacks (e.g., peanut butter, crackers, juices, applesauce, cookies, lemonade, sugar, cremora, hot chocolate)
Coffee and tea for parents and professionals
Small paper plates
Styrofoam cups and bowls
Small plastic cups
Cups with lids and spouts
Small pillows
Napkins
Kleenex
Handiwipes
Dish washing detergent
Bar soap
Spoons, forks, and knives
Small plastic bags (sandwich size)

FIT Clinic Equipment

Educubes (chairs)
Gymnastic ball for physical therapy
Speech mirror
Bolsters (made from foam bought at a wholesale foam and sponge rubber supplier)
Wedges (made from foam bought at a wholesale foam and sponge rubber supplier)
Corner seats (teacher made)
Beach balls for physical therapy and gross motor (16 or 18" diameter)
Tiltboard (balance disc)
Slide (indoor gym-house)
Mats (deluxe rest mats)
Bouncing tube
Rocking boat
Bean bag chairs
Swim rings - for positioning
Trunks for storage of small toys (two per clinic)
File boxes (small, portable for clinic notebooks)
Baby bath tubs (for rice play and water play)
Tote bags
Table
Potty chairs

Appendix F (continued)

Appropriate Toys for Curriculum Area

Language - Speech and Hearing

Sculptured farm animals
Toy telephone
Mirrors
Music boxes
The Farmer Says (See and Say series)
Pictures (for naming objects and actions)
Bells
Drums
Dolls
Wind toys (pinwheel, bubbles, whistles, pipes, kazoo toy horn)
Records (e.g., Songs We Sing at School by Hap Palmer)
Picture books (e.g., Pat the bunny, Baby animals, The touch me book)

Fine Motor and Manipulative

Small rattles (to grasp and shake and to suspend)
Mobiles (to look at and swat)
Squeeze toys
Busy box
Soft doll
Fuzzy animals
Small colored cubes (for grasping, tapping together, stacking matching colors, counting)
Pull toy attached to string
Large pegs and pegboard
Small pegs and pegboard
Tactile mat pegboard and easy grip pegs
Form boards
Knobbed single piece puzzles
Single piece puzzles
Crayons or markers
Paper
Scissors
Building blocks - varying from large cardboard brick blocks to Playskool building blocks)
Jumbo beads and strings
Plastic slinkies
Man in cup, man in boat, man in turtle (for fitting objects into)
Xylophone, drums, bells (for hitting and shaking actions)
Ring stack
Threading sequence
Pounding bench

Appendix F (continued)

Cognitive

Mini copter - (pull string to get toy)
Pocket pal wind-up toys (for object permanence and problem-solving)
Musical clown (touch to hear music)
Shape sorting box
Jack-in-the-music box
Xylophone, bells, and drum (for discovering that actions produce consequences)
Cooking set (for pretend play)
Luncheon set (for pretend play)
Dolls
Top cubes for nesting
Color/shape abacus (for matching and sorting)

Gross Motor (including physical therapy)

Small and large balls (for throwing and catching)
Walking board
Wedges
Steps
Tyke bike (Playskool) or other riding toys
Sturdy doll carriage or market basket (for learning to walk)
Bouncing tube or small trampoline for jumping
Gymnastic ball for physical therapy exercises
Scooter board

Self-help

Small cups
  cups with lips
  cut out cups
  small narrow cups
Spoons
Bowls
Dycem (nonslip matting)
Tubing (enlarging handle grips)

Appendix F (continued)

Listings of Toys Found in Specific Catalogs

Many of the toys listed are available through several catalogs. The lists by catalogs are intended to be samples of toys that might be ordered from sample catalogs, not exhaustive and inclusive listings.

Educational Teaching Aids
159 West Kinzie Street
Chicago, Illinois 60610

Pram
Educubes
Balance beam
Cook set
Tea set
Nesting boxes
Knobbed puzzles
Jumbo form board
Pegboards

Constructive Playthings
1040 East 85th Street
Kansas City, Missouri 64131

Indoor gym-house (steps and slide)
Balance disc
Educubes
Rocking boat
Bouncing tube
Tumble ball
Safety bouncer
Coaster sled (use for small scooter board)
Sculptured farm animals
Rainbow building blocks
Constructive blocks (large cardboard brick blocks)
Toy telephone
Pound-a-round
Honey bear
Deluxe rattle assortment
Happy Apple
Long neck deer 'n dog
Baby mirror
Squeaky animal friends
Floating family
Peek-in-roller
Jumbo pegboard
Cobbler's bench
Sequential sorting box
Nuts and bolts

Appendix F (continued)

Corn popper
Mini-copter
Chatter telephone
Giant snap-lock beads
Deluxe rest mats
Tote-a-tune music box radio
Oscar the Grouch pull toy
Turn and learn activity center
Knobbed fruit puzzle
Beginner inlay puzzle
Tactilemat pegboard
Jumbo pegboards
Plush animal puppet
Teeter ball
The Farmer Says
Naming names
Naming actions
Speech mirror
Small pegs and pegboard
Cubical counting blocks
Cluster bells
Tea bell
Wrist bells
Tunable Tom Tom
Swiss melody bells
Rhythmn sticks

ABC School Supply, Inc.
6500 Peachtree Industrial Boulevard
Norcross, Georgia 30071

Rubber hedgehog
Chiming plush ball
Unbreakable play mirror
Baby's first blocks (sorting box)
Busy gym
Disney musical busy box
Baby drum drop
Animal grabbers assortment
Clik Claks
Fisher Price Floating Family
Letter wood blocks - Playskool
Baby gift pack assortment of rattles - Fisher Price
Lolly - Fisher Price
Colored wood blocks - Playskool
Rock-a-stack - Fisher Price
Chime ball - Fisher Price
Oscar the Grouch - Fisher Price
Chatter telephone - Fisher Price
Turn and learn activity center - Fisher Price

Appendix F (continued)

Pull a tune xylophone - Fisher Price
Minicopter - Fisher Price
Snap lock beads - Fisher Price
Sort box
Six peg blocks - jumbo pegboard
Jumbo form board
Rhythmn band set
Pots and Pans
Tea set
Color stacking discs - Playskool
Jumbo wood beads - Playskool
First puzzles - Playskool
Pram - Learning products
Educube - Learning products
Teeter boat
Balance disc
Tyke bike
Riding horse
Rubber farm animals
Puppets
Tactilemat pegboard
Easy grip pegs

Acme School Supply
1807-A 21st Avenue South
Nashville, Tennessee 37203

Newsprint
Dial play phones
Jumbo beads and strings
One inch colored cubes
Brass hand bells
Economy bell
Crayons
Educubes
Pram
Tactile mat
Easy grip pegs
Letter wood blocks - Playskool
Colored wood blocks
Color stacking discs
Pegs
Pegboard
Rhythmn band instruments

Childcraft
20 Kilmer Road
Edison, New Jersey 08817

Developmental training ball

Appendix F (continued)

Childcraft - Program guidelines for children with feeding problems by Suzanne Evans Morris
Table blocks
Baby mirror
Learn a steps
Rocking boat
Balance board
Table blocks
Blockbusters
Pick-up truck
Rubber farm animals
Aluminum cooking set
Aluminum luncheon set
Bells
Drums
Knobbed puzzles
Beginner puzzles
Toy cubes
Threading sequence
Pounding bench
Color/shape abacus
Color stacking discs
Large pegboard

Preston
71 Fifth Avenue
New York, New York 10003

Rocker balance square
Non-slip matting (Dycum)
Prone crawler
Balance beam
Bouncing tube
Preschool trampoline
Ankle and wrist weights
Neuro-developmental training balls
Tubing (to enlarge handle grips)

Special Education Materials, Inc.
484 South Broadway
Yonkers, New York 10705

Educubes
Balance disc
Jumbo pegboard, tactilemat
Easy grip pegs
One inch colored pegs
Pram

Appendix F (continued)

Achievement Products
P.O. Box 547
Mineola, New York 11501

Jumbo pegboard

Discount Department Store

Plastic slinkies
Stuffed animals - piggy, teddy bear
Large balls
Beach balls
Nerf balls
Tubby Turtle - Playskool
Raggedy Ann
Raggedy Andy
Jack-in-the-box
Mattel See'n Say Zoo Keeper
Kohner Busy Box
Queen Buzzy Bee - Fisher Price
Xylophone
Pinwheels
Play dough

Appendix F (continued)

Catalog Listing

ABC School Supply, Inc.
6500 Peachtree Industrial Boulevard
Norcross, Georgia 30071

Achievement Products, Inc. - Catalog for Handicapped and Developmentally Delayed
P.O. Box 547
Mineola, New York 11501

Acme School Supply
1807-A 21st Avenue South
Nashville, Tennessee 37203

American Guidance Service - Peabody language kits, pictures
Publishers Building
Circle Pines, Minnesota 55014

Be OK - adaptive equipment and self-help aids
Fred Sammons, Inc.
Box 32
Brookfield, Illinois 60513

Childcraft Education Corporation
20 Kilmer Road
Edison, New Jersey 08817

Community Playthings - adaptive equipment, outdoor play equipment, wooden blocks and toy
Rifton
New York 12471

Constructive Playthings
1040 East 85th Street
Kansas City, Missouri 64131

Dipsters Corporation - small wrist/ankle weights for physical therapy
265 Wyndcliff Road
Scarsdale, New York 10583

Educational Teaching Aids
159 West Kinzie Street
Chicago, Illinois 60610

Environments, Inc.
Early Childhood Division
P.O. Drawer V
Beaufort Industrial Park
Burton, South Carolina 29902

Appendix F (continued)

Equipment Shop - adaptive equipment
P.O. Box 33
Bedford, Massachusettes 01730

Help-Handicapped Educational Learning Products, Inc.-physical therapy and adaptive equipment
Box 9763
Sacramento, California 95823

Kaplan Corporation
600 Jonestown Road
P.O. Box 15027
Winston-Salem, North Carolina 27103

Lakeshore Curriculum Materials Co.
2695 E. Dominguez Street
P.O. Box 6261
Carson, California 90749

Motor Activity Equipment for Special Populations
Flaghouse, Inc.
18 West 18th Street
New York City, New York 10011

Preston Corporation - special education catalog
71 Fifth Avenue
New York, New York 10003

Special Education Materials, Inc.
484 South Broadway
Yonkers, New York 10705

Teaching Resources Corporation
100 Boylston Street
Boston, Massachusettes 02116

Appendix F (continued)

References for Making Toys at Home

Brooks, G., & Roseblatt, J. Things to save, things to make, and things to buy to help babies and young children grow and learn. Nashville: Peabody College - DARCEE Publication, 1972.

Gordon, I. Baby learning through baby play. New York: St. Martin's Press, 1970.

Gordon, I., Guinagh, B., & Jester, E. Child learning through child play. New York: St. Martin's Press, 1972.

Hutinger, P., Barker, R., Bartnick, D., Donsback, P., & Hommel, C. You can make it: You can do it. Macomb 0-3 Regional Project, 27 Horrabin Hall, Western Illinois University, Macomb, Illinois 61455, 1978.

Marzollo, J. Supertot. New York: Harper & Row, 1977.

Appendix G

FIT Project Parent Library

Appendix G

FIT Project Parent Library

Azrin, N., & Foxx, R. Toilet training in less than a day. New York: Simon & Schuster, 1974.

Brazelton, T. Infants and mothers: Differences in development. New York: Dell, 1969.

Brazelton, T. Toddlers and parents: A declaration of independence. New York: Dell, 1974.

Brooks, G., & Roseblatt, J. Things to save, things to make, and things to buy to help babies and young children grow and learn. Nashville: Peabody College - DARCEE Publication, 1972.

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Cliff, S., Gray, J., & Nymann, C. Mothers can help. Texas: El Paso Rehabilitation Center, 1977.

Finnie, N. R. Handling the young cerebral palsied child at home. New York: E.P. Dutton, 1974.

Gordon, I. Baby learning through baby play. New York: St. Martin's Press, 1970.

Gordon, I. Baby to parent, parent to baby. New York: St. Martin's Press, 1977.

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Granger, R. Your child from one to six. Washington, D.C.: U.S. Government Printing Office.

Green, M. Fathering: A new look at the creative art of being a father. New York: McGraw Hill, 1976.

Hanson, M. Teaching your Down's syndrome infant. Baltimore: University Park Press, 1977.

Horrobin, M., & Rynders, J. To give an edge: A guide for new parents of Down's syndrome children. Minneapolis: The Colwell Press, 1974.

Horstmeier, D., & MacDonald, J. Ready, set, go--talk to me. Columbus, Ohio: Charles E. Merrill, 1978.

Appendix G (Continued)

Johnson, V., & Werner, R. A step-by-step learning guide for retarded infants and children. New York: Syracuse University Press, 1975.

Knox, L. Parents are people too. Nashville, Intersect, 1978.

Levy, J. The baby exercise book. New York: Pantheon Books, 1975.

Marzollo, J. Supertot. New York: Harper & Row, 1977.

NCLH Legal Monograph: A Parent's Guide to Ensuring the Educational Rights of Children. National Center for Law and the Handicapped, South Bend, Indiana, 1978.

Pushaw, D.R. Teach your child to talk. Fairfield, New Jersey: Cebco Standard, 1976.

Raynor, S., & Drouillard, R. Get a wiggle on. Mason: Aehper, 1975.

Segal, M. From birth to one year. Rolling Hills Estates, California: B.L. Winch, 1974.

Segal, M., & Adcock, D. From one to two years. Rolling Hills Estates, California: B.L. Winch, 1976.

Swinyard, C.A. The child with spina bifida. Chicago: Spina Bifida Association, 1964.

Children's Books

Adams, B. Like it is: Facts and feelings about handicaps from kids who know. New York: Walker and Company, 1979.

Carle, E. The very hungry caterpillar. Cleveland: Collins-World.

Kent, J. More fables of aesop. New York: Parent's Magazine Press, 1974.

Kunhardt, D. Pat the bunny. Racine: Golden Press Western Publishing Company, Inc.

Scarry, R. I am a bunny. New York: Golden Press, 1963.

Scarry, R. Egg in the hole book. Racine: Golden Press Western Publishing Company, Inc., 1979.

Stein, B. About handicaps. New York: Walker, 1974.

Teddy Board Books. Baby's first mother goose. New York: Platt and Munk.

Appendix G (continued)

Teddy Board Books. Baby's first toys. New York: Platt and Munk.

Upham, E. Little brown bear. New York: Platt and Munk, 1942.

White, P. & E. The touch me book. Racine: Golden Press Western Publishing Company, Inc.

Appendix H

FIT Family Entry Packet

Appendix H

FIT Family Entry Packet

Core Handouts

1. Introductory Letter-description of the operation of the FIT clinic. (Sample included in Appendix H.)

2. "Playing Games with Your Child"-description of guidelines for implementation of activities with the child in the home. (Sample included in Appendix H.)

3. "Guidelines"- description of some basic teaching principles in working with a handicapped child. (Sample included in Appendix H.)

4. "Songs We Sing at School"-words and motions to the songs that are sung during the Hello Song Activity. (Sample included in Appendix H.)

5. "Rules for Talking"-pamphlet that outlines ways for parents to talk to their child that will enhance language development. This can be obtained at Intersect, 1101 17th Avenue, South, Nashville, Tennessee 37212.

6. "Your Child From One to Six"-addresses questions in child care and management. This DHEW publication (#OHD5)77-30026 can be obtained from your local congressperson.

7. "Handicapped Children-Understanding Them, Helping Them Grow"-description of the developmental functioning of children at infancy, one, two, three, four, and five years old. This can be obtained from the State of North Carolina, Office of Day Care Licensing, P.O. Box 10157, Raleigh, North Carolina 27605.

8. "Can Your Baby Hear?"-talks about ways to detect hearing losses for children under three years of age. This pamphlet can be obtained from the Alexander Graham Bell Association for the Deaf, 3417 Multiplace, N.W., Washington, D.C. 20007.

Optional Handouts

1. "One Step at a Time"- helpful suggestions about teaching, diagnoses, and resources for new parents of infants with handicaps. This booklet can be obtained by writing Closer Look, Parents' Campaign for Handicapped Children and Youth, Box 1492, Washington, D.C. 20013.

2. "Get a Wiggle On"-delightful and informative booklet on blindness in children. This can obtained from, AAHPER Publications, 1201 16th Street, N.W., Washington, D.C. 20036.

Appendix H (continued)

3. "To Give An Edge"-informative booklet on Down's syndrome children. This can be obtained from Colwell Press, 500 S. 7th Street, Minneapolis, Minn. 55415.

George Peabody College for Teachers
VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37203 TELEPHONE (615) 322-7311

John F. Kennedy Center for Research on Education and Human Development
Box 151, Peabody College • Direct phone 322-8423

Demonstration and Research Center for Early Education

Dear Parents, Family, and Friends Entering the Family, Infant, and Toddler Project:

We welcome you to our program. You are now ready to participate in the Family, Infant, and Toddler weekly clinic. This clinic aims to help parents with teaching their children during their early years.

What is the FIT Project all about? What is expected from you? What will you receive?

The FIT Project serves families with children from birth through four years of age, who are slow in developing certain skills. A parent/infant teacher and yourself form a team to help your child in learning these skills. In addition, we have asked you to invite a grandparent, brother, sister, another relative, or friend who spends a lot of time with your child to come with you to these weekly sessions. The first years of your child's life are an extremely important time for your child to learn. You are your child's first and most important teacher, so your participation in the FIT Project is necessary.

Once a week, on Mondays at the First United Methodist Church in McMinnville, we come together from 10:00-1:00. During that time several activities will take place.

First, there will be individual sessions with a parent/infant teacher, yourself, and the other family member or friend that you have invited, will choose and practice one or two activities with your child.

These activities will help your child learn skills in the following areas:

Gross Motor Skills - your child's ability to move his whole body - sitting, walking, crawling, and the like.
Personal-Social Skills - your child's ability to relate to other people, and to be able to feed him/herself, drink from a cup, help get dressed, etc.
Hearing and Speech Skills - your child's ability to listen to sounds, understand words and sentences, as well as be able to babble, say words and sentences.
Non-Verbal Communication Skills - your child's ability to visually examine toys and objects, grasp, and use them - such as seeing a raisin, picking the raisin up, and then putting the raisin in the mouth.
Manipulation Skills - Ways that your child uses toys and objects.

Appendix H (continued)

Cognitive Skills - your child's ability to explore and understand his/her world, play with toys in new ways, as well as problem-solving. Your child must learn such basic concepts as object permanence (that toys and people exist even when he is not touching them and cannot see them) and causality (that events happen because someone or something causes them to happen).

Verbal and Gestural Imitation Skills - your child's ability to pay attention to language and activities of other people, and perform them him/herself.

You will then be asked to spend a certain amount of time during the week, teaching these one or two activities to your child. Every week, when you come to the clinic, we will discuss what your child did and any problems that might have come up. We will then pick new activities as your child masters the ones that you and your child have worked on. What you do with your child during the week is just as important as what happens on Mondays in clinic.

Also, during the morning, you will meet together with other parents and staff. This will be a time to receive new information, and to share experiences.

Once about every six weeks, we extend a special invitation for any grandparents, relatives, and friends who are concerned about your child to join us in an evening meeting. We will share with everyone information about child development and other topics that are of interest and concern.

While the parents are meeting together, the children will participate in group activities with the other teacher. Also, the teacher will take note of the child's progress.

Some books and handouts will also be available for those people who are interested in reading more about certain subjects on children.

What do we expect of you?

Your participation in the clinic and at home is very important because the parent and the parent, infant, and toddler teacher form a team to help your child learn new skills.

What will you receive from the FIT Project?

Hopefully, information, help, and support in dealing with your child's development.

Suggestions:

- Dress yourself and your child comfortably when you come.
- If for some reason, you are unable to come for a Monday

Appendix H (continued)

morning session, please call and cancel your appointment as far in advance as possible. The FIT number is (Nashville) (615)327-8237. (Call collect.)

We are looking forward to working with you.

Sincerely,

Ann Carr

Ann Carr

Maria Donofrio

Maria Donofrio
Parent/Infant Teachers
FIT Staff

Appendix H (continued)

Guidelines

The following are some basic concepts that have been used in working with children who are delayed in their learning.

1. Skills and concepts are broken down into steps and taught sequentially. If a step cannot be mastered, it is broken down into more basic steps. Steps are not taught out of sequence.

2. Be concrete, bring abstractions down to earth with concrete analogies and examples. Use simple, direct language. Take no knowledge for granted. Often the definition of a simple word is the key to mastery of a skill or concept. Help the child to remember by offering association, repetitions. Ask the child to verbalize as he performs.

3. Reward. Since we all like rewards, give the child his/hers.

4. Practice makes perfect. After a child has mastered a skill, remember to give the child the opportunity to use it.

5. Use consistent methodology and environment. Avoid radical change of either.

6. Time is perhaps the biggest factor in teaching children who are delayed in their learning. This becomes a real test of instructor adaptability, innovation, and creativity. It is easy for activities to become wearisome and boring for both teacher and child. Creative approaches are encouraged rather than advancement to the next skill.

7. Success experiences. All tasks should be designed to show success. Many children have a history of failure from almost everything. Direct efforts towards convincing the child that he can cope successfully with his environment. And give lots and lots of exposure to the environment. The child can't cope with the environment if he/she is protected from it.

8. Conduct tasks in a casual, no-stress manner. Try to build positive attitudes towards mobility. Having fun is very important in learning.

9. Give immediate and constant feedback. This reinforces desired behavior.

10. TLC--A necessary ingredient (Carroll, 1961) warmth and personal revelation. Touch children, not in the reassuring way that sighted have of holding hands with the blind, but to make the experience a personal and human experience.

11. Use as many tangible touching aids as you can. Tactile and auditory input together are more effective.

Appendix H (continued)

12. Use reality. Accept as few substitutes for reality as possible. Use real food instead of play food, real animals at the children's zoo rather than stuffed or plastic animals, etc.

Adapted from Mike Corbett, 1975

Appendix H (continued)

Playing Games With Your Child

Taking time to play games with your child is very important. Your child can learn a lot of important skills from play. And besides, it helps to make the learning more fun for your child as well as yourself.

There are some important things to remember:

When to Use the Games

1. Choose a time of day when your child is rested, fed, and generally in a good frame of mind.
2. Choose a time of day when you are relaxed and free of other immediate responsibilities. It is important that this time with your child be relaxed and fun.

How Long to Play

1. Your first attempts with the activities should be short, but fun. Begin by playing with the game for 5 or 10 minutes. For very young children (under 18 months) 3-5 minutes may be best.
2. You can play the game longer as your child learns the game and enjoys it. The activity should be ended before the child loses interest in it.
3. If your child does not show interest in the game, do not punish him/her. Simply put the material away and try another day. If your child doesn't show any interest any day, let the FIT teacher know. It may not be the appropriate game for your child to play.

What to Expect

1. The first stage may be one of indifference, especially if the game is new to your child. Your child may have to be shown and guided through the steps.
2. The next step, the child may begin to pay attention and to begin to smile and show that he is interested in the game.
3. Next the child usually begins to participate in the game. He/she may watch and try to take part in the game, though not perfectly.
4. As the child gets better at playing the game, he/she gets closer and closer to what is expected for him/her to do.
5. The final step is for the child to play the game on his/her own without being encouraged or coaxed each time.

Adapted from the Mama Lere Home. Parent/Teacher Manual

Appendix H (continued)

Songs We Sing At School!

Bumble Bee

I'm bringing home a baby bumble bee.
Won't my mommy be so proud of me cause
I'm bringing home a baby bumble bee.
Buzzy - buzzy - buzzy - buzzy
Oops! He stung me.

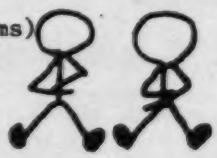
(hands clasped, up and down in rhythmn)

(bring hands up in startled position)

Bus Song

The wheels on the bus go
Round and round
Round and round
The wheels on the bus go
Round and round
All through the town.

(roll arms)



The horn on the bus goes
Beep, beep, beep
Beep, beep, beep
The horn on the bus goes
Beep, beep, beep
All through the town.

(beep nose with index finger)

The wipers on the bus go
Swish, swish, swish
Swish, swish, swish

(hold hands palms straight out and move hands in semi-circle)

Appendix H (continued)

The wipers on the bus go

Swish, swish, swish

All through the town.

Two Ducks

Two little ducks that I once knew	(hold index finger up on each hand)
Tall one	(hold hands vertically to show height)
Fat one	(hold hands horizontally)
There were two	(hold up index finger on each hand)
But the one little duck	(hold up one index finger)
With the feather on his back	(place hand in the middle of the back, palm out and move up and down)
He led the other with his	
Quack, quack, quack.	(place thumbs under arms and move up and down)
Down to the river they would go	
Wibble-wobble, wibble-wobble	(hands on hips, elbows moving forward and back)
To and fro	
And the one little duck	(see above)
With the feather on his back	
He led the others with his	
Quack, quack, quack.	

Little Froggies

Little froggies	
Hop, hop, hop	(fist, hands, knuckles out and move up and down)
Little froggies	
Stop, stop, stop!	(hands up, palms out, move forward and back)

Appendix H (continued)

<u>Monkey Song</u>

Two little monkeys	(hold up one index finger on each hand)
Jumping on the bed	(stamp feet against floor)
One fell off	(hold up index fingers and move one to the side)
And bumped his head	(place palms of hands over ears, move head from side to side)
Mama called the doctor	(place fisted hand over the mouth and move the other fisted hand in a circular motion around the ear)
And the doctor said	
No more jumping on that bed	(shake index finger from side to side)

(Repeat same as above, but with one monkey instead of two. At end ask child how many monkeys are left and say, "None, all gone". Move hands palms down in lap; then bring arms up and out to side with palms facing upward.)

<u>HI</u>

Hi____(child's name)_____, (wave hand)

Hi_____,

We want to say "Hi_____"

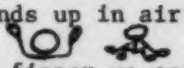
Hi_____, Hi_____

We like you very much!

<u>Bunny FuFu</u>

Little Bunny FuFu	(index and middle finger make rabbit ears and "hop" across midline)
Hopping through the forest	
Scooping up the field mice	*(make downward sweeping motion with hand)

Appendix H (continued)

And bopping them on the head	**(hit side of head with hand)
And down came the good fairy	(put both hands up in air and bring to floor) 
And this is what she said	(shake index finger up and down)
Little Bunny FuFu	("hop" bunny across midline as above)
I don't want to see you	(shake finger back and forth)
Scooping up the field mice	(see * above)
And bopping them on the head.	(see ** above)

Our Hands*[2]

Open, shut them,

Open, shut them,

Give a little clap, clap, clap.

Open, shut them,

Open, shut them,

Lay them in your lap.

Creep them, creep them

Creep them, creep them

Right up to your chin

Open up your mouth

But do not let them in.

*[2](with your hands - just do what the song says - use both hands - touch each part of your body as you sing)

Clap

Clap them, clap them

Softly clap

Clap them, clap them

Roll them over, over slow

Now get ready, off we go.

Touch Your Body

Head and shoulders, knees and toes

Knees and toes

Head and shoulders, knees and toes

Knees and toes

Appendix H (continued)

Eyes and ears and mouth and nose

Head and shoulders, knees and toes.

Spider Song

The itsy bitsy spider — *(walk index and middle finger of one hand up the opposite arm)

Went up the water spout

Down came the rain — (bring hands up in the air, move hands toward the floor wiggling the fingers)

And washed the spider out. — (bring hands together, palms down at midline, quickly move the hands, palms still down, straight to the side)

Out came the sun — (make circle with hands and arms above the head)

And dried up all the rain

And the itsy bitsy spider

Went up the spout again. — (see * above)

If Your're Happy

If you're happy — *1. "clap your hands"
2. "pat your head"

And you know it - — 3. (any motion your child readily performs, such as "shake your hands")

If you're happy

And you know it

Then your face — (put hands on either side of the face and sway your head from side to side)

Will surely show it

If you're happy

And you know it -

Appendix H (continued)

Two Blackbirds

Two little blackbirds	(hold up index finger on each hand - bounce hands up and down)
Sitting on a hill	
One named Jack	(put one hand, with index finger up forward;
One named Jill	move that hand back and bring the other hand forward)
Fly away Jack, Fly away Jill.	(move one hand behind back, and then move the other hand behind back)

Turtle Song

There was a little turtle	(put the middle finger and thumb together forming a "curved shell" with all the fingers)
Who lived in a box	(place the other hand over the "shell")
He swam in the water	(bend hands, palms out at midline and move the hands in circular swimming motions) ("walk" the index and middle fingers of one hand up the arm)
And climbed on the rocks	
He snapped at a mosquito!	(clap the hands as each insect is named with an outward motion)
He snapped at a flea!	
He snapped at a fly!	
And he snapped at me!	
He caught the mosquito!	(reach outward with palm up, close the fingers into the palm as the arm is brought toward the body)
He caught the flea!	
He caught the fly!	
But he didn't catch me!	(wave finger back and forth, and shake head "No")

Appendix H (continued)

Goodbye

Goodbye everybody	(wave bye)
Goodbye everybody	
Goodbye everybody	
We're sad to see you go.	(put hands under eyes and pretend to cry)
Hope you had a happy time	(clap in beat)
Happy time, happy time,	
We're sad to see you go.	

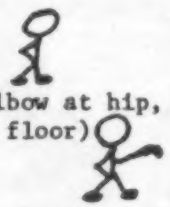
Thumbkin

Where is thumbkin*	(hands behind the back)
Where is thumbkin	
Here I am	(bring one hand around body with thumb up)
Here I am	(bring other hand around body with thumb up)
How are you today, sir?	(wiggle one thumb up and down as if talking to the other thumb)
Very well I thank you.	(wiggle the other thumb in the same manner)
Run away.	(move one hand back behind the body)
Run away.	(move the other hand behind the body)

*Song goes on - pointer (index finger), tall man (middle finger), ring man (ring finger), pinky (little finger).

Tea Pot Song (Stand up song)

I'm a little tea pot	(point to yourself)
Short and stout.	
Here is my handle	(put hand on hip)
And here is my spout	(put other arm - elbow at hip, hand bent, palm toward floor)



Appendix H (continued)

When I get all steamed up

Then I shout

Just tip me over and pour me out. (bend at waist)

Records We Listen To

Hap Palmer - "Getting to Know Myself"

Hap Palmer - "Learning Basic Skills Through Music" I & II

Hap Palmer - "Learning Basic Skills Through Music Vocabulary" III

Hap Palmer - "The Feel of Music"

Hap Palmer - "Moving"

Ella Jenkins - "You'll Sing a Song and I'll Sing a Song"

Fran Powell - "Hum and Strum with Fran Powell"

Woody Guthrie - "Songs to Grow On"

Appendix I

Sample Physical Therapy Evaluation Report

Appendix I

PHYSICAL THERAPY EVALUATION
December 15, 1980

Marty is a 20 months old child with Down syndrome who has been seen twice previously in physical therapy at the FIT Project. She has been attending the program regularly and the mother has actively been participating in the physical therapy activities.

On evaluation, Marty was very cooperative and attempted many new activities during the session. She continues to have generalized hypotonia but not to the same degree as seen in May 1980. She did not have the heart surgery that was scheduled for May but the mother states that surgery may be done in March 1981. Her heart defect does not seem to be limiting her gross motor activities at this time.

Marty is presently functioning at the 12 months level in gross motor skills at this time. She has made a gain of four months in motor skills during the past seven months. This is much better progress than was seen between January 1980 and May 1980. She is coming to sitting using rotational patterns at times, but also uses straight flexion patterns. She is now able to get on hands and knees and is using a cross diagonal pattern for creeping. Although she uses a reciprocal pattern, she keeps the left leg extended and abducted as she creeps. Marty has also begun pulling to standing by coming to half kneeling and then pulling to standing. Once standing, she is able to cruise holding on to furniture or the wall and is able to go from one piece of furniture to another. Marty is able to walk with both hands held and has good flexion - extension patterns but she has a wide base of support. She tries to walk with one hand held but twists towards the side being held when she walks.

Marty continues to have good labyrinthine righting responses. She has developed a good Landau response and gets into pivot prone on her own. She continues to have plantar grasp bilaterally. She continues to have good responses to slow tilting in sitting and is beginning to shift her weight from one leg to the other when tilting slowly in standing (side to side but not back and forth).

Marty appeared to have better oral control today. The mother continues to ice occasionally and feels that this is helping with lip closure. Marty is beginning to chew well and is being given table foods. The mother was instructed to continue with activities for lateralization of the tongue and for lip closure. An inferior pincer grasp is being seen when Marty picks up small objects.

Physical therapy activities will be given for improvement of overall muscle tone, for improvement of balance in standing and for stimulation of independent standing and walking. The activities should be appropriate for four to six months.

Barbara H. Connolly, RPT, Ed.D.

Appendix I (continued)

Physical Therapy Activities December 15, 1980

1. Place weights in a small push cart or into the baby walker and have Marty push the walker.

2. Sit Marty on a small riding toy. Allow her to push backwards then pull her feet forward to get her to pull to you with her feet. Have her ride for distances of at least 10 feet.

3. Place Marty standing with her back against the wall. Have her reach across midline to get a toy. Have her reach above her head, out to the side and down near the floor. Also get her to toss a ball to you to stimulate her to pull away from the wall.

4. Place Marty standing facing away from you but support against your chest. Bend her forwards to touch her toes and then have her come back to standing. Repeat at least five times.

5. Place Marty on her stomach on the beach ball. Roll her back onto her feet firmly to get her to place weight on her feet. Also stand her holding onto the beach ball with her hands and slowly rock the ball from side to side to get her to shift her weight from one foot to the other.

6. Sit Marty in a small chair (one that allows her feet to touch the floor). Hold a toy over her head and try to get her to stand on her own to get the toy.

7. Walk Marty up steps holding her hand (only one hand) but make her use her legs instead of her arms by not holding the arms above shoulder level.

8. Have Marty hold onto a broom handle (or like object) with both hands. Have her stand holding on while you hold one end of the stick. Gradually let go of the stick as she begins to balance more on her own.

   With Marty still holding onto the stick, begin walking forwards with her. Let go of your support via the stick as Marty balances more on her own.

9. Stand Marty on the tilt board and slowly tilt from side to side to get Marty to shift her weight from one leg to the other.

10. Stand Marty in front of a mirror and hold her at the waist. Have her sway from one side to the other, shifting her weight from one foot to the other.

Appendix I (continued)

11. Encourage Marty to walk from one object to another. Try this with chairs placed short distances apart and then gradually increase the distance between chairs.

Barbara H. Connolly, RPT, Ed.D

Appendix J

Sample Individual Educational Plan

Family, Infant and Toddler Project
Individual Educational Plan

Child's Name: Jenny Wright

Address: 712 Ball Avenue
McMinnville, Tennessee 37110

Parents Name: Mary and John Wright

Phone: 765-7004

Clinic Site McMinnville

Date: 2/81

Placement Meeting:

Location: McMinnville & Nashville

Decision: Continued enrollment in FIT

program offered Home/parent training

basis

who is responsible John and Mary Wright, Elizabeth Gerlock

Review date: long range 8/81
short range 5/81

% of time in FIT intervention program:

Evaluation Report due by:

IEP - Planning and Conference:

Planning and meeting - 2/9/81

Evaluation - 4/10/80

Re-evaluation scheduled - 3/81

IEP document date: 2/26/81

Additional Services for Child

P.T. evaluation - Barbara Connelly - 12/80

We hereby, agree to the educational decisions stated above:

Date:

Family, Infant and Toddler Project

Individual Educational Plan

Child's Name Jenny Wright Case Manager Elizabeth Gerlock Date 2/81 Clinic Site McMinnville

Current Developmental Status: Jenny finds an object hidden under 1 or 3 screens; she puts a round shape in the formboard; she pulls a string to get a toy.

Developmental Areas: Gross Motor, Personal Social, Hearing and Speech, Eye Hand Coordination, Manipulation, Object Permanence, Means-Ends, Verbal Imitation, Gestural Imitation, Operational Causality, Spatial Relationships, Scheme Actions, Non-Verbal Communication, Cognitive Pre-Operational Stage.

Long Range Goals: Jenny will demonstrate an understanding of likenesses and differences in size and shape by matching objects, nesting cups, and completing puzzles.

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
1. Jenny will put 3 shapes in the formboard.	Jenny will put the circle, square, and triangle in the formboard within 3 minutes (trial and error acceptable) at 3 consecutive clinic sessions.	2/81	8/81	
2. Jenny will nest 3 boxes of different sizes.	Jenny will nest 3 boxes, each of which is at least 2" larger/smaller than the others, within 3 minutes (trial and error acceptable) at 3 consecutive clinic sessions.	2/81	8/81	
3. Jenny will match objects that are exactly alike.	Jenny will match 4 objects to the corresponding objects by putting them together when the objects are presented 2 at a time at 2 consecutive clinic sessions.	2/81	8/81	

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
4. Jenny will sort objects	Given an array of objects, Jenny will separate objects into groups with 3-5 identical objects in each group.	2/81	8/81	

Family, Infant and Toddler Project

Individual Educational Plan

Child's Name Jenny Wright Case Manager Elizabeth Gerlock Date 2/81 Clinic Site McMinnville

Current Developmental Status: Jenny picks up small objects; drops objects in a cup; makes a tower of two, and puts large pegs in the pegboard.

Developmental Areas: Gross Motor, Personal Social, Hearing and Speech, Eye Hand Coordination, Manipulation, Object Permanence, Means-Ends, Verbal Imitation, Gestural Imitation, Operational Causality, Spatial Relationships, Scheme Actions, Non-Verbal Communication

Long Range Goals: Jenny will demonstrate increased ability to relate objects to each other by stacking blocks, putting pegs in a pegboard and removing a top; Jenny will demonstrate increased eye-hand coordination by drawing and stringing beads.

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
1. Jenny will stack 3-4 blocks.	Jenny will stack 3-4 one inch cubical blocks at 3 consecutive clinic sessions.	2/81	8/81	
2. Jenny will put small pegs in the pegboard.	Jenny will put 6 small pegs in the pegboard at 3 consecutive clinic sessions.	2/81	8/81	
3. Jenny will learn to control the direction of her crayon	(a) Jenny will imitate a vertical stroke at 3 consecutive clinic sessions.	2/81	8/81	
	(b) Jenny will imitate a circular stroke at 3 consecutive clinic sessions.	2/81	8/81	
4. Jenny will use wrist and hand rotation to remove the top from a jar.	Jenny will turn a top at least 2 revolutions to remove it and obtain the contents at 2 consecutive clinic sessions.	2/81	8/81	

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
5. Jenny will put beads on a wire.	Jenny will put 5 large beads on a wire at 3 consecutive clinic sessions.	2/81	8/81	

Family, Infant and Toddler Project

Individual Educational Plan

Child's Name Jenny Wright Case Manager Elizabeth Gerlock Date 2/81 Clinic Site McMinnville

Current Developmental Status: Jenny understands many directions and will perform an action requested. She uses 4 word approximations and understands many words.

Developmental Areas: Gross Motor, Personal Social, Hearing and Speech, Eye Hand Coordination, Manipulation, Object Permanence, Means-Ends, Verbal Imitation, Gestural Imitation, Operational Causality, Spatial Relationships, Scheme Actions, Non-Verbal Communication

Long Range Goals: Jenny will increase the interpretability of her communication by (a) using her voice to attract attention and (b) increasing her use of specific words by 10 words. Jenny will demonstrate her understanding of pictures, body parts, and clothing by pointing on cue.

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
1. Jenny will point, gesture, and vocalize to indicate needs.	Jenny will gesture and vocalize to indicate what she wants 4 times at home and 2 times in the clinic.	2/81	8/81	
2. Jenny will use words spontaneously.	Jenny will use 5-10 words spontaneously either to name familiar objects or familiar people 4 times at home and 2 times at clinic.	2/81	8/81	
3. Jenny will point to pictures named.	Given a choice of 4 pictures and a request to point to one of the pictures. Jenny will point to the correct pictures unassisted 3 out of 4 times at 3 consecutive clinic sessions using 12 different pictures.	2/81	8/81	
4. Jenny will point to body parts she has not already learned.	Jenny will point to her arms, hands legs, and feet on request at 3 consecutive clinic sessions.	2/81	8/81	

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
5. Jenny will point to clothing.	Jenny will point to her shoes, socks, shirt, and pants on request at 3 consecutive clinic sessions.	2/81	8/81	
6. Jenny will follow directions.	Jenny will follow 2 directions given randomly (i.e. give it to me; put it in the box) at 2 consecutive clinic sessions.	2/81	8/81	

Family, Infant and Toddler Project

Individual Educational Plan

Child's Name Jenny Wright Case Manager Elizabeth Gerlock Date 2/81 Clinic Site McMinnville

Current Developmental Status: Jenny sits alone, comes to sit independently, and combat crawls

Developmental Areas: Gross Motor, Personal Social, Hearing and Speech, Eye Hand Coordination, Manipulation, Object Permanence, Means-Ends, Verbal Imitation, Gestural Imitation, Operational Causality, Spatial Relationships, Scheme Actions, Non-Verbal Communication

Long Range Goals: Jenny will demonstrate increased strength in her arms by holding the wooden stacking ring over her head.

Jenny will demonstrate increased balance in sitting by keeping her balance when rolled slowly backward on the beach ball.

Jenny will demonstrate improved rotational patterns by reaching to the opposite side for a toy while seated straddling a bolster

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
1. Jenny will develop more strength in her arms.	(a) Jenny will reach for a heavy toy held over her head, weekly at home and at least 2 times a month at the clinic.	2/81	8/81	
	(b) Jenny will pull herself forward 5 feet on the scooter board at 6 consecutive clinic sessions.	2/81	8/81	
	(c) Jenny will place her full weight on her hands while on her stomach over a small beach ball 2 times a week at home and at least 2 times a month at the clinic.	2/81	8/81	
	(d) Jenny will wear 1/4 lb. weights around her wrists 10 minutes a day at home.	2/81	8/81	
	(e) On her stomach over the beach			

Short-Term Objectives	Evaluation Criteria	Initiation Date	Projected Date	Attainment Date
	ball, Jenny will push herself up on her arms as she is rolled forward at 6 consecutive clinic sessions.	2/81	8/81	
2. Jenny will develop her stomach muscles and balance in sitting.	(a) Jenny will do 10 sit ups daily with an adult holding her hands. (b) While sitting on the beach ball Jenny will use her muscles to keep her balance when rolled backward and sideways at 6 consecutive clinic sessions.	2/81	8/81	
3. Jenny will improve her balance in sitting and her rotational patterns.	(a) Jenny will hold herself steady in a sitting position when pushed firmly backwards, forwards, and to the sides at least 2 times a week at home and at 6 consecutive clinic sessions.	2/81	8/81	
	(b) When Jenny is steated straddling a bolster, she will reach across midline with each hand, over her head with both hands, out to the side with each hand, and down to the floor with each hand at 6 consecutive clinic sessions and 2 times a week at home.	2/81	8/81	

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